

**CONVERSATION BETWEEN NURSES AND
PATIENTS WITH APHASIA:
HOW TO STAY OUT OF TROUBLE**

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ABSTRACT

This study aimed to investigate the conversational practices used by nursing staff interacting with patients with aphasia in a rehabilitation health care setting. Six dyads, each comprising of a qualified nurse and an adult with moderate to severe aphasia, were videotaped conversing in the hospital, yielding an hour of data. The conversations were transcribed in detail and subjected to conversation analysis (the ethnomethodological type), in order to identify the practices used by the partnership to negotiate meaning and achieve social satisfaction. An emphasis was placed during analysis on the strategies used by the nurses, in order to generate insights that could be applied to partner training. Analysis of the data revealed a pattern of nurses avoiding visible trouble in the conversations, which was accomplished by minimizing the interactive consequences of repair, glossing over potential sources of trouble, and managing the conversation in a manner that limited the potential for trouble to occur. The interactive advantages and disadvantages of this strategy of are discussed, along with theoretical and clinical implications.

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1. INTRODUCTION AND REVIEW OF THE LITERATURE

This study concerns the way that conversation is conducted between adults with aphasia and the nurses who care for them, in a rehabilitation hospital setting. It provides a description of patterns observed in nurse-aphasic interaction, which were uncovered from natural data using conversation analysis methodology. This endeavour was motivated by a need to inform training programmes for nursing staff on interacting with aphasic patients, based on insights derived from observation of actual behaviours. The impetus for this study comes from the rise of pragmatic and psycho-social approaches to aphasia, and the increasing use of conversation analysis in aphasiology as both a theoretical descriptor and clinical tool. The background to these trends, as well as a description of conversation analysis methodology and its application to aphasia, are explained below.

1.1 Aphasia and conversation: background

This study is set against a context of an increasing interest in aphasiology towards naturalistic conversation, partner training, and communication within the health care system. This interest stems from both pragmatic and psycho-social approaches to aphasia. For over two decades, pragmatic approaches have focused on how communication is achieved by people with aphasia in natural contexts (for example, Holland, 1982; Penn, 1987). More recently, this “functional” view has been expanded into a social or psycho-social approach, which considers the wider interpersonal and social impact of aphasia (Simmons-Mackie, 2000), and targets intervention at promoting participation in life (Worrall, 2000). Common to both perspectives is an interest in conversation: in pragmatics, this is the site where real-life communication is achieved, and for social approaches, it is the medium through which individuals with aphasia participate in a social world.

Realizing the significance of conversation

Speech-language therapists have increasingly recognized the centrality of conversation to human life, and its essential role in maintaining psychosocial well-being (Kagan & Gailey, 1993). Conversation is not merely an exchange of information: it involves intricate social negotiations to affiliate, maintain distance, preserve identity and maintain face (Simmons-Mackie, 2000). In aphasia, it is the difficulties in conducting conversation, usually the means through which one reveals one’s competence, that cause social isolation (Kagan, 1995). As

Kagan and Gailey (1993, p 203) point out, in all spheres of living – family, work, social – “conversation is the common currency that enables people to function normally.” Wilkinson (1995, p 271) also comments on how, “in practice, talking with others will be the most distressing aspect of aphasic communication.” Conversation therefore deserves more of a central role in aphasiology and aphasia intervention than it has historically been given.

One of the reasons that conversation is so crucial to psychosocial well-being is its inherent duality in function: while it entails talk or verbal activity, conversation is at the same time “a vehicle through which selves, relationships and situations are socially constructed” (Schriffin, 1988, p 272). Brown and Yule (1983) label these dual goals transaction (exchange of information) and interaction (creating a social relationship). Proponents of a social model of aphasia emphasize that these functions are equally important (Simmons-Mackie, 2000), although it is transaction that has traditionally been emphasized in intervention.

Working with the conversation partner

A focus on conversation naturally leads to a focus on the conversational dyad or partnership. It is impossible to consider an aphasic person’s contributions to a conversation independently from those of their interlocutors, as conversation is fundamentally a collaborative process (Milroy and Perkins, 1992). The realization that communicative competence is vested in both members of the dyad has provided clinicians with a new field for intervention, i.e. partner training. Kagan et al (2001) demonstrate how altering the skills of the non-aphasic partner can bring about dramatic improvements in conversation. Kagan and Gailey (1993) advocate for an extension of the role of the speech-language therapist to address the psycho-social handicap of aphasia by training conversation partners. Thus, there have been several recent efforts to target the skills of aphasic people’s communication partners as a means to improving the success and satisfaction of their interactions (such as Supported Conversation for Aphasia (Kagan, 1998), Communication Partners (Lyon et al, 1997), SPPARC (Lock et al, 2001).

Being able to alter the behaviour of conversation partners requires detailed information on what happens in a conversation. In order to focus this type of intervention, it is necessary to gain an understanding of what constitutes a “good” or “bad” speaking partner (Simmons-Mackie & Kagan, 1999). The factors that make one conversation partner successful, and another not, are probably complex. With the rise of partner-based interventions, there have

been calls for more detailed knowledge on how interaction works at conversational level, to provide principles for clinical practice (Simmons-Mackie, 1998; Holland, 1998).

This end has been primarily achieved using conversation analysis (CA), a methodology that has gained increasing prominence in aphasiology over the last decade. Recent studies have used CA to describe features of the conversational interactions of aphasic/non-aphasic dyads (Lindsay & Wilkinson, 1999; Laasko & Klippi, 1999; Ferguson, 1996), as well as being directly used as a tool to guide and evaluate partner training (Wilkinson et al, 1998; Cunningham and Ward, 2003; Booth and Perkins, 1999). A more detailed description of the basic premises of CA, and its application to aphasia, follows below.

1.2 The purpose and methodology of conversation analysis

Origins of conversation analysis

CA emerged in the late 1960's as part of the wider sociological movement of ethnomethodology, which investigates how social order and social interaction are created through the common sets of procedures used by society's members (Lee, 1987). The pioneering work of Harvey Sacks, Emmanuel Schegloff and Gail Jefferson (such as Schegloff and Sacks, 1973; Sacks et al 1974; Schegloff et al 1977) demonstrated that naturally-occurring conversation is not a formless or haphazard event, but a process with complex interactional rules, procedures and conventions, which can be analytically uncovered by the researcher. This work has formed the basis for a number of splinter concerns, such as institutional discourse, doctor-patient interviews, courtrooms, classrooms, and now aphasic conversation.

The purpose of conversation analysis

The primary aim of ethnomethodological CA is to study how social action is accomplished in conversation (Schriffin, 1987). At its most basic, this objective is one of describing the procedures by which conversationalists produce their own behaviour and understand and deal with the behaviour of others (Heritage and Atkinson, 1984). A central assumption of CA is that all aspects of social organization (including conversation) exhibit organized patterns of stable, identifiable social features (Goodwin and Heritage, 1990). The goal of CA is then to explain how this orderliness is accomplished.

Conversation analysis methodology

Ethnomethodology is a bottom-up, data-driven approach. Similarly, CA is distinctive as a methodology in that it posits initially no set of analytic or organizational principles, but inductively seeks patterns in bodies of naturally occurring data (Schriffin, 1987). Knowledge of communicative competence is not intuitively assumed, but has to be inferred through the analysis of structures and patterns in conversation.

CA focuses on the local organization of talk, which involves consideration of minute, step-by-step details of the conversation (Heritage and Atkinson, 1984). As well as looking at the details of conversation, analysis moves beyond the isolated sentence and encompasses the sequences within which individual actions occur and are linked to one another.

An analysis of this nature is dependant on a detailed transcript of the interaction, taking into account such fine details as pausing, pacing, false starts, interruptions, laughter and non-verbal cues. Data collection is done through video/audio recording, so that details of the data can be repeatedly reviewed. Conversation analysts then usually work with a collection of fragments of conversation in order to explicate a single phenomenon (Schegloff, 1988).

Unlike much conventional sociology, CA aims to be rigorous and richly empirical (Lee, 1987). This is achieved firstly by an insistence on the use of naturally occurring examples of everyday interaction (as opposed to imagined or experimentally produced data). Secondly, CA aims to confine its analysis to the observable features of the interaction (Heritage and Atkinson, 1984). These prerequisites give CA inherent validity and empirical grounding.

CA is essentially a qualitative methodology. Due to the inherent sequential nature of conversation, quantitative methods are not ideally suited to analysing this type of discourse - when an utterance is taken out of context for "counting", it becomes meaningless (Schegloff, 1993).

1.3 The application of conversation analysis to aphasia

There has been an upsurge of interest in CA as applied to people with aphasia in the last decade. As Hesketh and Sage (1999, p 239) put it, "this is the next logical step on the road to a meaningful and realistic consideration of the effects of communication impairment."

Damico et al (1999) note that conversational behaviour is becoming more important, due to greater focus on the dyad and partners (discussed above). There are a number of reasons why CA presents itself as an advantageous tool for aphasiology.

Working with real-life language

The usefulness of CA in aphasiology lies firstly in the fact that it fundamentally considers language in context (Lesser, 2003). Whereas more traditional approaches to aphasia have involved sampling language at word and sentence level, in a de-contextualized clinical setting, CA is concerned only with language produced in interaction, on-line, and in-use, making it an intrinsically functional index of language ability. CA is a method of analysis that involves real-life aphasic talk-in-interaction, which aphasiology is ultimately trying to describe and explain (Wilkinson, 1995). It has the analytic power to focus on complex social actions and to describe how and when these actions are employed (Damico et al, 1999). It also shows how the socially sensitive aspects of aphasia are revealed and dealt with, as examining conversation allows us to see interactive norms through which people's interactive goals, selves and relationships are negotiated (Schriffin, 1987). Thus, CA allows researchers to investigate the social and communicative impact of aphasia on individuals in real-life settings.

The ecological validity of conversation analysis

Unlike many of the formal and functional descriptions of language that have been used previously, CA inherently has strong ecological validity. This is ensured by the use of real interactions as the basis for analysis, and a data-driven approach that emphasizes the description of observable behaviour (Perkins, 1995). CA does not make judgements on language based on presumptions of abnormality or inappropriacy, but derives them internally from the flow of the conversation (Lesser, 2003). This practice of seeking evidence of communicative success or failure in the sequential context of conversation allows a move away from prescriptive judgements of adequacy.

Conversation as a collaborative effort

CA holds a major advantage for aphasiology as it clearly recognizes the role of the conversation partner and the responsibility he/she has in achieving a successful conversation. CA explicitly treats conversation as a collaborative achievement (Schegloff, 1982), thus stressing the joint responsibility of both interlocutors. The dyad, not the individual, is the

subject of investigation. CA allows a view of the dynamic flow between speakers (Ferguson, 1994), which emphasizes the need to work with both the individual with aphasia and his/her conversation partner. The skills and strategies of the non-aphasic partner are recognized as being crucial in communicative success.

Focus on conversational detail

Finally, CA is the only approach to pragmatics that explicitly takes account of minute details such as filled and unfilled pauses, overlaps, repetitions and repairs – phenomena with which aphasic conversation is generally replete (Milroy and Perkins, 1992). Therefore, CA directly considers the level of pragmatic difficulty typically experienced by individuals with aphasia.

Clinical application to partner training

CA has gained attention in clinical aphasiology because it can be specifically focused on how aphasia impacts on the conversational success of the dyads. While targeting therapy at conversation is not a new idea, using CA allows a more rigorous assessment of conversation upon which to base therapy (Wilkinson et al, 1998). Damico et al (1999) suggest that greater awareness of the complexities and systemacity of the conversational context will greatly enhance service delivery to individuals with aphasia. The application of CA to clinical aphasiology has thus provided detailed guidelines on how to train conversation partners on use of specific adaptive strategies in interacting with the aphasic individual. Several studies have demonstrated the effectiveness of this approach (Booth and Perkins, 1990; Wilkinson et al, 1998).

Within aphasiology, investigators have based their work on CA's ethnomethodological model but have shown some adaptations to, if not radical departures from, its fundamental principles (Hesketh and Sage, 1999). This work therefore falls into domain of applied CA, a term which is used to (amongst other things) refer to efforts to apply CA findings to advise people and organizations on how specific practical problems might be handled in order to facilitate smooth and effective practice (ten Have, 2001).

1.4 Some central analytic concepts in conversation analysis

In the 40 or so years that conversation analysts have studied talk-in-interaction, a large body of work has been built up describing their findings. CA in aphasiology is built on the back of such studies. A brief introduction to some of the concepts used in this study is provided

below (further detail may be found in the many introductory texts on this subject, e.g. Atkinson and Heritage, 1984; Button and Lee, 1987).

Turns and turn-taking

In CA, the basic unit of conversation is the “turn at talk”, which participants exchange between themselves (Heritage and Atkinson, 1984). One of the most striking accomplishments of everyday conversation is the way that participants manage the conversational floor and share out turns with split-second timing and minimal overlapping talk (Lee, 1987). Sacks et al (1974) propose that this exchange occurs systematically, with conversationalists following a set of rules that allow participants to recognize who should speak when. The rules apply at various transition-relevance points (TRP), which mark possible completion points in a current speaker's turn. At each TRP, the next turn will either be allocated to the next speaker, or retained by the current speaker (by other-selection or self-selection). Speakers have to work within this system and manipulate it to their intentions (Goodwin and Heritage, 1990). It has been noted that aphasics are more vulnerable to loss of the floor, as their linguistic impairments give rise to pauses (Lesser and Milroy, 1993).

Some turns at talk are minimal (e.g. “mm”, “oh”). These minimal tokens have various functions depending on their sequential placement, such as acknowledgement, continuation or preparedness to shift into role of listener (Jefferson, 1984a). Discourse devices such as these have an important function in regulating the interaction (Schriffin, 1987).

Sequentiality, adjacency pairs and preference

One of the fundamental features of CA is the idea that an utterance must be understood in the sequential context that it occurred. Any utterance constitutes the immediate context for the following utterance – it projects or “sequentially implicates” what may follow it (Heritage, 1984). This allows mutual understanding, as turns are assumed to make sense in relation to one another (Schegloff and Sacks, 1973). Sequentiality thus refers to the way in which an utterance is constructed so as to display its relation to the immediately preceding utterances, and to make expectable a certain type of utterance in the following turn.

A basic item in CA is the “adjacency pair” (Heritage and Atkinson, 1984), which consists of a pair of mutually dependant utterances. Some highly familiar examples of adjacency pairs are question/answer, and greeting/response. The first part of an adjacency pair projects a relevant

next action, or range of actions, to be accomplished by another speaker in a next turn (Schegloff and Sacks 1973). Adjacency pairs thus strongly constrain linear sequencing in a conversation (Goodwin and Heritage, 1990).

Some turns are constructed to prefer a certain type of answer, such as agreement (Sacks, 1987). For example, a question can be built in such a way as to exhibit a preference between a “yes” or “no” response (e.g. “Isn’t it beautiful?”).

Intersubjectivity

Conversation is fundamentally oriented towards achieving mutual understanding – speakers are motivated by the need to know that their messages have been received and understood (Schriffin, 1987). Intersubjectivity is the display by participants that they each understand each other’s talk and actions in the conversation. Displays of mutual understanding are achieved largely implicitly (Schegloff, 1992). For example, a participant’s next turn at talk will display their interpretation of a preceding turn (Heritage and Atkinson, 1984) – it is thus through sequentiality that understanding is reached. CA studies are generally studies of understanding, and of the way in which understanding is achieved in conversation (Lee, 1987). This makes CA especially relevant to aphasia, where linguistic difficulties can create a barrier to understanding, which the partnership must overcome.

Trouble, repair and saving face

Achieving intersubjectivity in conversation is not always a smooth process – it often has to be negotiated. In both normal and aphasic conversation, problems in speaking, hearing and understanding are dealt with in an organized way to restore understanding (Lesser and Milroy, 1993).

Problems in conversation are referred to as trouble. Trouble in conversation can be described as difficulty in communication, which is signalled by the interactants (Schegloff et al, 1977). “Trouble” is used rather than “error”, as the concepts are not synonymous – one can easily occur without the other. This approach orients to what the partners in the conversation treat as problematic, rather than focusing on one individual’s linguistic difficulty (Lesser and Milroy, 1993).

The term repair refers to a variety of behaviours that the conversation partnership use to deal with troubles in talk – a “self-righting” mechanism to allow the conversation to continue in the face of difficulties with understanding (Schegloff et al, 1977). This has been a major topic of interest for aphasiologists, as there aphasia gives rise to many potential trouble sources, and the methods by which this trouble is resolved will determine the overall success of the conversation.

The most widely-used approach to describing repair is that devised by Schegloff, Jefferson and Sacks (1977). This model highlights the distinction between self-repair and other-repair (depending on whether the speaker or the hearer carries out repair), as well as self-initiated repair and other-initiated repair (reflecting which partner indicates a need for repair). Thus, repair may or may not be initiated and carried out by the same speaker. Ferguson (1994), applying CA to aphasia, draws a distinction between interactive and non-interactive trouble-indicating behaviours. More common in aphasia is interactive repair, where the two partners collaborate in resolving the trouble, with the partner with intact linguistic abilities possibly taking on more of the conversational work.

While similar principles operate in aphasic and normal conversation for carrying out repair, Milroy and Perkins (1992) point out that the standard CA approach to repair needs to be adapted in order to handle the complex organization of aphasic repair, which seems to be structurally different from normal repair in several respects. For example, repair in aphasic conversation spans a much longer sequence than in normal conversation, and other-repair is much more frequent (Lesser and Milroy, 1993). Clark and Schaefer’s (1987, 1989) model of contributing to conversation has been found to be useful for describing this process. This model is explicitly collaborative, highlighting how interlocutors work together to establish that the listener has understood what the speaker has meant. Interlocutors must provide positive evidence of understanding, or mark points where a presentation needs repair work. Central to the model is the principle of least collaborative effort, whereby participants strive to minimize the total effort spent on accepting a contribution. Milroy and Perkins (1992) have shown how this principle operates in aphasic conversations, where the non-aphasic partner takes over the repair-work, allowing quicker resolution of trouble.

An idea common to both Schegloff et al (1977) and Clark and Schaefer’s (1987) models is that of the relative strength of repair initiation. A hierarchical ordering of other-repair

initiators, from giving a paraphrase (strong) to requesting repetition (weak), has been proposed, depending on how accurately the initiator focuses the need for repair by pinpointing the source of the trouble. Strong repair generally results in less “time out” of the conversation, as it requires less input from the original speaker. Generally, participants adhere to the principle of least collaborative effort in resolving trouble, so that minimal conversational disruption is ensured (Perkins et al, 1999). This is why in conversations with aphasics, the non-aphasic partner usually takes over the work of repair, as they have greater linguistic resources with which to effect it.

Repair can be an interactionally delicate matter. As Lindsay and Wilkinson (1999) point out, explicit references to the need for repair may be a threat to face, as they reveal a partner as non-competent. The notion of “face” comes from Goffman’s work in sociology (1955, 1959), and refers to one’s socially validated image of self. Individuals in interaction strive to maintain their face, and the face of others, in order to sustain social order and prevent embarrassment. Schegloff et al (1977) stress that there is a preference for self-repair in conversation, which allows a speaker to maintain face, but in aphasia self-repair is not always possible. In conversations with people with aphasia, trouble is highly prevalent and may be a source of frustration and awkwardness. Studies on aphasic conversation have shown how repair can be managed in such a way as to minimize the interactive consequences of trouble, or to bring it to the surface of the conversation in a way that can threaten the face of the aphasic participant (Ferguson, 1994, Simmons-Mackie and Kagan, 1999, Lindsay and Wilkinson, 1999).

1.5 Review of studies using conversation analysis in aphasia

Studies applying CA to aphasia have accumulated in the last decade. They have shown that although aphasic conversation may differ structurally to non-aphasic conversation, the principles through which it can be understood are the same (Lesser and Milroy, 1993). CA has been used as a tool for both description and intervention in aphasia. The following four studies have been selected to illustrate the theoretical background for this study.

Laasko and Klippi (1999) elaborate on the nature of word-search sequences in aphasic conversation, where partners attempt to collaboratively reach mutual understanding of the topic. Data was derived from conversations in speech therapy sessions with three aphasics. They demonstrate that in aphasic conversation, word search is a visible activity, which often

initiates a collaborative problem-solving sequence, traditionally called a “hint and guess” sequence (Lubinski et al, 1980). Four distinct phases are proposed, which are quite similar irrespective of the type of aphasia: establishing a problem, establishing a collaborative co-operation phase, hinting and guessing, and a long confirmation phase. Most importantly, the participants were shown to agree to collaborate before embarking on the word-search. The participants still appeared to display a preference for self-management of trouble – the aphasics would try to repair their own utterances first, and clearly shift orientation to co-participant to invite collaboration.

Ferguson (1994) investigated the influence of aphasia, familiarity and activity on conversational repair, using both qualitative and quantitative methods. Data was collected from nine participants with mild to moderate-severe aphasia in conversation with familiar and less familiar partners (all friends or family members). The frequency of interactive trouble-indicating behaviour (i.e. metalinguistic comment and hypothesis forming), and the nature of repair patterns were considered. The results of the study provided empirical evidence for increased trouble and interactive repair in aphasic conversation, which had previously been assumed but not directly investigated. Analysis also showed that the more unfamiliar partners made higher use of other-repair, a strategy usually associated with greater threat to face. The author suggests that other-repair provides a swift remedy for trouble, enabling a quick return to the flow of conversation. On the other hand, allowing or prompting the aphasic to repair their own turns runs a higher risk that trouble will continue, thereby risking a more extended face-threat. It is possible that only the more familiar partners were willing to risk this. Different individual styles of repair were observed, some naturally more facilitative than others.

Lindsay and Wilkinson (1999) compared the conversation of two aphasic/spouse partnerships and two aphasic/speech-language therapist partnerships, and found that repair was handled differently between them. Spouses were more likely to explicitly bring repair to the surface of the conversation (e.g. using initiators like “what?”), and prolong it by encouraging a collaborative revision of aphasic errors. This was considered unusual, as repair was then extended beyond the point where the target became known. Speech-language therapists, however, were reluctant to model production, which helped to ensure that similar sequences did not occur in these conversations. A wider review of repair phenomena revealed that while speech language therapists worked to minimize the interactive consequences of aphasic

troubles in talk, spouses played a part in prolonging and exposing repair. The authors note how potential trouble sources may be pursued or “glossed over” (avoided). This study demonstrates again how the non-aphasic partner influences how talk is repaired, and how a facilitative partner can manage threat to “face”.

Simmons-Mackie and Kagan (1999) investigated the features that make conversations successful by analysing four aphasic-volunteer dyads, with two volunteers rated by judges as “good” communicators and two as “bad” communicators. Discourse devices and resources employed by speaking partners in dyads were identified. It was found that the good communicators used more acknowledgement tokens, more congruent overlaps of talk and non-verbal behaviour (e.g. laughing), fewer disjunct markers, more willingness to accommodate the aphasic’s style of communication, and more completion of clarification sequences (whether successful or not) with mutual agreements. An overriding theme to explain these structural differences in talk was seen to be the partner’s judgement of the aphasic’s competence. Good partners used strategies that helped the person with aphasia save face, rather than emphasize exchange of complete or accurate information. They reinforced the image of the person with aphasia as competent, trustworthy, interesting and sincere, and promoted affiliation and solidarity through the structure of discourse. The authors point out how this has implications for training conversation partners – rather than targeting superficial features of conversation, intervention should focus on changing perceptions of aphasia.

Overall, the studies that provide the background to this study deal with the ways that trouble is managed in aphasic conversation – either in a manner that minimizes its interactive consequences and maintains conversational flow, or in a manner that reveals the aphasic to be non-competent and explicitly brings trouble to the surface. These differences have been shown to be largely dependant on strategies of the non-aphasic partner.

1.6 Rationale for the study – partner training in the health care setting.

Against this background of interest in aphasic conversation and partner training, the present study aimed to address interaction within a health care setting, specifically, with the nursing staff in a rehabilitation hospital.

Why a health care setting?

The importance of communication in health care has become increasingly recognized.

Conversation is a critical element in effective delivery of health-care, not only just in terms of professionals having “rapport” with patients, but also in creating improved technical quality of healthcare (Roter & Hall, 1993). McCooley et al (2000) point out how communication is linked to quality care in the hospital setting, and Pye et al (2000) how there is growing focus on communication problems in extended care facilities. Makoni (1998), writing from a sociolinguistic perspective, explains how caregiving is interactionally accomplished: language practices are embodied in care, and an analysis of the language practices of caregivers can give insight into the quality of care that is rendered.

Communication is coming to be understood in terms of the ICF (World Health Organization, 2001), which encompasses the level of participation (handicap) as well as the more traditional areas of impairment and activity (disability) (Worrall, 2000). This places an emphasis on the psychosocial and behavioural aspects of communication in a health care setting. Both Lomas et al (1989) and Le Dorze et al (1994) show (via surveys) how residents in a long-term hospital do not interact with nursing staff only about daily care needs, but also engage in social forms of communication. However, it has been shown that care staff frequently place limited value on the role of communication in a patient or resident’s quality of life - there is likely to be minimal interaction in extended care facilities and if communication does occur, quality is often impoverished (Lubinski, 1995).

Despite the importance of talk in health care, this setting seems a somewhat under-represented area in CA aphasiology studies. This study aimed to redress this. Nurses are the health professionals who have the most contact with the patient, and effective communication is considered to be an essential aspect of nursing care (Ashworth, 1984). Nursing staff were thus the natural targets for investigation in this study, as the group with the greatest potential to make a difference in participation for patients with aphasia.

The scope for intervention

In a rehabilitation hospital, nurses come into frequent contact with aphasic in-patients, with whom they may interact for a variety of purposes. Care staff in this setting are expected to cope with a range of complex communication problems (Bryan and Maxim, 1998). McCooley et al (2000) point out how communication barriers in the health care setting may be caused by

staff-related communication difficulties, such as lack of skills, knowledge and awareness. This can pose a significant barrier to participation for people with aphasia in the health setting (Kagan, 1995). The proposed solution has been to train the staff interacting with patients, as part of a socio-environmental approach to language intervention in the health care setting (McCooley et al, 2000). Kagan and Le Blanc (2002) advocate for an expanded role for speech-language therapists, involving training partners to ensure more communicative access in the health care system. Training nurses could act to minimize the disabling effects of aphasia in this setting, and promote better quality of life for aphasic hospital in-patients. By focusing on the dimension of participation, speech-language therapists can utilize the limited resources available to them to provide services relevant to the needs of consumers (McCooley et al, 2000).

The role of CA would then be to provide information upon which to base training, and to evaluate the efficacy of training. CA has typically been used to provide individualized advice to carers, but it is a methodology that is also able to uncover insights that are applicable to more generic training (as demonstrated by Simmons-Mackie and Kagan, 1999). To be effective, training for nurses should be based on observed features of their conversations, rather than on work that has been done predominantly with family members or volunteers. As Worrall (2000) points out, there is a need to identify the simple and complex communicative activities that occur in the lives of aphasic clients, using ethnographic research methods – only then can intervention be focused on relevant functional outcomes.

This study was thus instigated in order to provide insights to inform training programs for nurses, based on CA-generated observations of nurse-aphasic conversations.

2. METHODOLOGY

2.1. Aims of the study

This study aimed to investigate the practices used by nursing staff in conversation with adults with aphasia in a rehabilitation hospital setting, using conversation analysis as a tool to describe how the participants negotiated meaning and achieved social interaction. The study was motivated by the need to gain insights into aphasic conversation in this setting, to guide training for nurses and other conversational partners.

2.2. Research Design

This qualitative study applied ethnomethodologically-based conversation analysis to data collected from multiple cases. Conversation analysis was selected as a powerful and empirically rigorous qualitative methodology that allows detailed consideration of patterns of behaviour within conversation, and has the sensitivity to reveal social processes within the interaction.

2.3. Setting

The data for this study was collected in a sub-acute rehabilitation hospital (90 beds), situated in an urban centre in South Africa. A large percentage of the in-patient population had sustained recent cerebro-vascular accidents, and were undergoing rehabilitation before returning home or being placed in other permanent residence. The average length of stay in this hospital was six weeks.

As patients at this hospital receive rehabilitation as in-patients, nursing care plays an integral part of this stage of recovery. Nurses interact with patients daily in this environment as part of performing medical procedures, assisting with activities of daily living, interviewing for medical records, and everyday social contact. The nursing and care staff at this hospital consisted of registered nursing sisters, enrolled nursing auxiliaries, and untrained carers.

2.4. Participants

Six conversation dyads took part in this study, each comprising of a nurse and an adult with aphasia.

2.4.1. Participant selection criteria

2.4.1.1. Nursing staff

The nurses participating in this study were required to be enrolled nursing auxiliaries (ENAs), a title that refers to nurses who have completed one year of formal nursing training. This section of the nursing staff was selected, as they were responsible for most of the skilled and basic nursing care in the hospital. They therefore had the greatest opportunity to interact with patients, both as part of care-giving and socially.

Nurses were required to be proficient in English (as the conversations had to take place in English, the researcher's first language). All the ENAs at the hospital met this requirement, as English is a common language of medical interactions in this setting.

2.4.1.2. Participants with aphasia

Adults with aphasia participating in this study were required to meet the following criteria:

- Diagnosed with aphasia by a speech-language therapist.
- Presenting with a communication disability that was moderate to severe in degree. Such participants would have deficits in understanding/using language that caused marked difficulties in everyday interactions. This portion of the aphasic population were targeted for this study as they were the most likely to have difficulties with conversation, and are thus most in need of supportive conversation partners.
- Medically stable and alert.
- Fluent in English (that is, on a first-language level pre-morbidly), as the data was collected in English. Patients who were most fluent in a language other than English were thus excluded from the study (note: aphasic participants were required to speak English as a home language, whereas nursing staff were merely required to have proficiency in English. This was designed to make English the natural language choice in the conversations).
- Patients with significant cognitive or sensory losses were excluded from the study.

2.4.2. Recruitment

All six nurses participating in the study were recruited from the hospital staff. Potential participants were approached verbally in the hospital, and then recruited on the basis of willingness to participate. None of the nurses approached were unwilling to participate.

Five of the participants with aphasia were recruited from the in-patient population receiving speech therapy for aphasia. One aphasic participant was a previous patient at the hospital, and was residing at an old age home in the area at the time of the study. Potential subjects were approached using Supported Conversation techniques (Kagan, 1998) to explain the nature of the study and what their participation involved. None of the adults with aphasia approached were unwilling to participate.

2.4.3. Description of participants

2.4.3.1 Nursing staff

Demographic information for the nurses that participated in the study is presented in Table I.

2.4.3.2 Participants with aphasia

Demographic and diagnostic information on the adults with aphasia participating in the study is presented in Table II. A more detailed description of each of the participants with aphasia is provided in Appendix A.

Nurses and participants with aphasia were paired into six dyads based on their availability in the hospital at the time of data collection. This resulted in quasi-randomization of subjects, as no planning was involved in dyad allocation.

2.5. Ethical considerations

Participation in the study was voluntary and carried no risks. Participant's confidentiality has been respected, by using coded initials to refer to participants and altering names contained in the data.

All subjects gave informed written consent to participate in the study. Participants with aphasia were informed of the study using Supported Conversation techniques (Kagan, 1998), in order to ensure full understanding and genuine consent. Copies of the consent forms used for nurses and aphasic participants are included in Appendix B. Translations of consent forms were made for nurses who spoke a language other than English as their first language. Assent was also sought from a significant other or family member of the participant with aphasia.

Table I: Demographic information on nurses participating in the study

Case	Age	Gender	First language	Proficiency in English	Culture	Training	Years of employment at hospital
1 (SF)	39	Female	Afrikaans	Proficient	White	ENA	8
2 (TR)	45	Female	Afrikaans	Fluent	Coloured	ENA	7
3 (AR)	41	Female	Afrikaans/English	Fluent	White	ENA	10
4 (SS)	48	Female	Afrikaans/English	Fluent	Coloured	ENA	9
5 (RC)	45	Female	Afrikaans	Fluent	Coloured	ENA	12
6 (LV)	38	Female	Xhosa	Fluent	Xhosa	ENA	10

ENA = enrolled nursing auxiliary

Table II: Demographic and diagnostic information on adults with aphasia participating in the study

Case	Age	Gender	First language	Culture	Site of lesion	Time post-onset	Receptive impairment	Expressive impairment	Other conditions
1 (H)	54	Female	English	Coloured	Left MCA infarct	6 weeks	Mild-moderate	Severe	Right hemiplegia
2 (D)	62	Female	English	Coloured	Large left MCA territory infarct	7 weeks	Very mild	Extremely severe	Right hemiplegia Apraxia of speech
3 (G)	60	Female	English	Coloured	Left external capsule infarct	4 weeks	Mild	Moderate	Moderate dysarthria
4 (A)	38	Female	English	Coloured	Left capsular and basal ganglia infarct	4 weeks	Mild	Moderate-severe	Right hemiplegia
5 (W)	83	Female	English	White	Left basal ganglia infarct	8 months	Very mild	Severe	
6 (S)	59	Female	English	Coloured	Left putamen and internal capsule bleed	8 weeks	Mild	Severe	Right hemiplegia

See Appendix A for more detail regarding severity ratings of receptive and expressive impairment.

2.6. Data Collection

2.6.1. Procedure for data collection

Each dyad (consisting of a nurse and an adult with aphasia) was recorded conversing in a private room in the hospital. Nurses were instructed to converse with aphasic patients in the manner that they normally would (see Appendix C for exact instructions to nurses). It was suggested that the conversation could be facilitated by finding out about the patient's biographical information, medical history and perceptions of the hospital (a type of conversation frequently encountered between patients and health care workers - Kagan et al, 2001), although the partners were encouraged to converse on any topic they chose. Paper and pens were provided, although no explicit instruction to use them was given.

It must be noted here that ethnomethodological conversation analysis should take place using naturally-occurring conversations, as these provide a richer and more representative example of social behaviour than an artificial situation can offer (Heritage and Atkinson, 1984). The conversations in this study were, of course, not spontaneously occurring, and thus (despite their unconstrained nature) lose some of their naturalistic elements. Due to practical limitations, collecting a sufficient sample of spontaneously occurring nurse-aphasic interaction would have proved difficult. Nevertheless, considering the aims of the study, this data is still useful, for the following reasons:

- The data will still reveal the manner in which nurses and aphasics collaborate to reach mutual understanding in conversation. While the more macro-structural elements of the interactions might be affected (e.g. topic choice), the more micro-structural elements (e.g. repair) will be less likely to change (as observed by Pomerantz and Fehr, 1997).
- Similar data-collection procedures have been employed by other researchers on aphasic conversation (for example, Simmons-Mackie and Kagan, 1999), and have yielded a rich source of information for analysis.

The aim of the research was not to provide a comprehensive, representative description of how nurses talk to aphasics in natural conversation, but rather to investigate the possible strategies that nurses and aphasics can use to accomplish conversation together – and these will be apparent even in the more contrived situation used in this study.

Twenty minutes were allocated for the interview, although nurses were encouraged to converse for about ten minutes to provide sufficient data for analysis. The participants were entitled to terminate the conversation whenever they chose.

In order to avoid observer's paradox (Milroy, 1987), the researcher was not present during the conversation, and the video camera was introduced in the setting before the interview so that its presence could be as unobtrusive as possible.

2.6.2. Instrumentation

The conversation was recorded using a video camera (Sony Video Hi8 Camcorder) mounted on a tripod. Video was used as the primary source of data, in order to capture the non-verbal aspects of interaction that can be crucial in aphasic conversation (Bryan et al, 1998b).

2.6.3. Transcription

Conversations were orthographically transcribed from the video recording, using the conventional transcription notations developed by Gail Jefferson (see 2.9 below). Relevant non-verbal and paralinguistic information was also included in the transcript. As Heritage and Atkinson (1984) point out, any transcription system is necessarily selective, and inclusion of information must be balanced against the readability of the transcript. The transcript included all audible verbal information, timing of pauses and indication of speech overlap, with notes made on intonation, volume, rate, eye gaze, gesture and posture, where these appeared relevant to the conversation. In this way, an effort was made to address both inclusiveness and readability.

2.6.4. Amount of data collected

The data collection yielded almost an hour of conversation in total. The length of each conversation is represented in Table III below.

Table III: Length of recorded conversations

Case	Nurse	Participant with aphasia	Length of conversation
1	SF	H	7 minutes 48 seconds
2	TR	D	7 minutes 7 seconds
3	AR	G	6 minutes 50 seconds
4	SS	A	8 minutes 10 seconds
5	RC	W	13 minutes 50 seconds
6	LV	S	12 minutes 30 seconds
TOTAL:			56 minutes 15 seconds

2.7. Data Analysis

Analysis of the data, using CA methodology, focused on the behaviours of the nurse (as the target of intervention), rather than the person with aphasia (although the latter was naturally taken into account, since conversation is reciprocal and collaborative). The nurses' behaviours were considered in terms of how they contributed to negotiation of meaning (transaction) and social satisfaction (interaction) within the exchange. The intention of the analysis was to describe the salient features of the interaction in a manner that reflected their contribution to successful (or unsuccessful) conversation. Two stages of analysis were used in order to achieve these ends.

The first stage of data analysis involved a cyclical review of the video-taped conversations, creating an increasingly-detailed record of the observed behaviours, along with an increasingly-detailed transcription. This yielded a sequence-by-sequence, turn-by-turn description of the interactions, with an emphasis the demonstrable effect of the nurses' behaviours on the conversation. Initially, data was viewed with only the broad aim of noting how the conversation was accomplished, rather seeking out specific behaviours highlighted previously in the literature. This "bottom-up" approach is central to CA, in order to alert the researcher to details of interaction that may not be noticed if pre-conceived categories are used (Goodwin and Heritage, 1990). From this first-stage description, recurring patterns were identified and examples demonstrating these collected. Thus, the salient interactional features upon which the study came to be focused emerged inductively from the data during analysis.

The second stage of analysis was then carried out using the patterns and practices identified in the first stage. Patterns of particular interest were explored and compared to give an account of the nurses' actions in the conversations. Specific examples were selected to demonstrate general patterns. At this stage, practices were compared to other examples in the CA and aphasiology literature.

While analysis initially took place on a case-by-case basis, the data corpus was treated as a whole during the second stage. This was done so as to illustrate findings that occurred across the cases, thus seeking generalities rather than features specific to particular cases.

As a final step, consideration of how the observed practices accomplished the dual goals of transaction and interaction in the conversation was undertaken. Thus, an understanding of

how mutual understanding and social satisfaction were accomplished (or not accomplished) in conversations was sought.

2.8. Reliability and Validity

In terms of the reliability of the data, the transcript was developed over repeated viewings of the video tape (this being used as the primary source of data), to ensure the most accurate transcript possible. The extracts used as examples in the results were subjected to particularly close scrutiny to ensure that interpretation was based on a true observation of behaviour.

Reliability indices are not usually necessary for research involving conversation analysis, as both the analyst and the reader have direct access to the data about which analytic claims are being made (Damico et al, 1999). However, in a study of this nature, it was necessary to report on information that was not contained solely within examples of data (e.g. reflecting on the frequency with which a particular pattern occurred). Although using quantification could have provided information on the frequency with which relevant behaviours occurred, the data was found to be resistant to such an approach. This supports Schegloff's (1993) assertion that quantification is antithetical to CA, as an action becomes meaningless when removed from its sequential context for counting.

As confirmation of the study's findings could not be obtained by comparing different judges' counts of behaviours, a more general audit of the data was undertaken to ensure the reliability of the researcher's interpretations of the data. This review involved two other qualified speech-language therapists with experience in adult aphasia (one familiar with CA, the other relatively new to it). Each reviewer separately watched the data (in video form), and was required to rate and comment on the presence of particular patterns of behaviour. The purpose of this was to establish agreement on the perceived saliency of key behaviours in the conversations. A rating scale (included in Appendix D) was used as a guide, so that reviewer's perceptions could be easily compared (although it would not have been appropriate to generate numerical indices of inter-rater agreement from this guide).

Conversation analysis has been widely recognized as a viable means of ensuring valid data analysis and interpretation (Damico et al, 1999). Validity is ensured by making observable conduct the central resource for analysis, and basing observations demonstrably on what is made relevant by the participants (Heritage and Atkinson, 1984). This study strove to do this

as far as possible, although at times it became appropriate to look beyond the superficial implications of behaviours.

The ecological validity of CA stems from its use of naturally occurring data. This was somewhat compromised in this study due to the contrivance of the data collection situation. Careful consideration of this fact was exercised in interpretation, in order to avoid emphasizing behaviours that were merely the product of an artificial situation. Retrospective consideration of this issue appears in the general discussion.

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2.9. Transcription notations

The transcription symbols used here are based on those developed by Gail Jefferson, and are common to conversation analytic research.

- (0.5) The number in brackets indicates a time gap in tenths of a second.
- (.) A dot enclosed in a bracket indicates a brief untimed pause (less than two-tenths of a second).
- = The equals sign indicates “latching” between utterances (utterances that follow immediately from one another).
- [] Square brackets between adjacent lines of concurrent speech indicate the onset and end of a spate of overlapping talk or action
e.g.
9 SF: When are you going home?
10 H: (0.3) go:ing ho:[me-
11 SF: [Tomor[row?
12 H: [((nods))
- (()) A description enclosed in a double bracket indicates a non-verbal activity, such as a gesture. When occurring simultaneously to speech, the gesture appears below the relevant section of talk, with brackets indicating where it begins and ends.
- A dash indicates a sharp cut-off of the prior word or sound.
- : Colons indicate that the speaker has stretched the preceding sound or letter. The more colons, the greater the extent of stretching.
- ! Exclamation marks are used to indicate an animated or emphatic tone.
- . A full stop indicates a stopping fall in tone.

- , A comma indicates “continuing” intonation.
- ? A question mark indicates rising intonation.
- under Underlined fragments indicate speaker emphasis.
- hh An “h” indicates an audible breath (the more h’s, the longer the breath).
- (guess) Words within a single bracket indicate transcription doubt, with the best guess at an unclear utterance.
- (xxx) An “x” within a single bracket indicates an unintelligible syllable. The number of syllables in un-transcribable words are indicated by the number of x’s.
- Arrows in the left margin point to specific parts of an extract discussed in the text.

3. RESULTS AND DISCUSSION

The repeated viewing, description and analysis of the sequences in the six conversations resulted in a particular interpretative theme being developed. This concerned the ways in which the nurses created, displayed and ensured mutual understanding, or at least the impression thereof. Three main patterns in interaction were identified that account for this action:

- 1) The ways that nurses minimized the interactive consequences of repair
- 2) The nurses' tendency to "gloss over" potential trouble sources at times
- 3) The way nurses managed the conversation so as to limit potential sources of trouble.

This particular theme was chosen for its theoretical and clinical interest and relevance to the field. As consistent with CA methodology, illustrative extracts of the data are presented below with a description and interpretation of the practices used by the participants. Each pattern has been evaluated in terms of how it contributes to transaction (information exchange) and interaction (social relationship), which are the equally important dual goals of conversation (Simmons-Mackie, 2000).

3.1. Minimizing the interactive consequences of repair

As discussed in the introduction, "repair" refers to a variety of behaviours that the conversation partnership use to deal with troubles in talk (Schegloff et al 1977). Repair becomes more frequent in aphasic conversation due to the increased difficulties partners have making themselves understood. Repair is an interactionally delicate matter, as explicit references to a need for repair can constitute a threat to face, as they reveal a partner to be non-competent (Lindsay and Wilkinson, 1999). Previous studies in aphasia have shown how different partners may attempt to minimize the interactive consequences of trouble, or to bring it to the surface of the conversation, the former pattern being viewed as the more "face-saving" one (Simmons-Mackie and Kagan, 1999). In the data in this study, it was this "better" pattern of minimizing the consequences of repair, with the least "time out" from the conversation as possible, that was predominantly noted.

3.1.1. Strong repair

It has been noted by many researchers (e.g. Milroy and Perkins, 1992; Laasko and Klippi, 1999) that trouble in aphasic talk is often repaired collaboratively. This means that the non-aphasic participant may attempt to provide missing words to resolve trouble in the aphasic's

contributions. Making a guess at their intended meaning is one way of doing this, as shown in case 1.

- 17 SF: And whose gonna take care of you at home
18 H: (mene tori)
19 (0.5)
20 → SF: Husband?
21 H: (nay oh)
22 SF: No?
23 H: ((nods))
24 (0.6)
25 → SF: a nurse?
26 H: No
27 (0.6)
28 → SF: a::: daughter?
29 H: Ye:s
30 SF: She's gonna take care of you.
31 H: ((nods))

Here, SF has asked a question (17 – “and whose gonna take care of you at home”), which as the first part of an adjacency pair, projects a relevant action (an answer) to be accomplished by the next speaker (Schegloff and Sacks, 1973). H’s answer (18 - transcription doubt, sounds like “mene tori”) is treated as problematic by SF, who initiates repair with a guess in 20 (“husband?”). H rejects SF’s hypothesis, and SF has to pose two others (25 – “a nurse?” and 28 - “a daughter?”), before being accepted.

Firstly, this is an example of other-initiated other repair, as SF is indicating that H’s contribution is troublesome, and attempting to fix it herself. While Schegloff et al (1977) stress that self-repair is overwhelmingly preferred in conversation (i.e. the speaker fixes their own utterance), other-repair is one pattern that is more commonly seen in a “word search” situation. This makes it a very common pattern in aphasic conversation, where word-finding difficulties are common (Wilkinson, 1995). As Lesser and Milroy (1993) point out, aphasics struggle to self-repair due to difficulties with syntactic/lexical retrieval problems. Here, other-repair is a more facilitative strategy, allowing the participants to come to an agreed-upon answer with a minimum of effort.

Secondly, SF’s attempt (20 - “husband?”) is a strong form of repair, i.e. a candidate guess, rather than a weak form (such as “hmm?” or “what?”). Strong repair usually takes the form of a paraphrase or a guess that can be accepted or rejected by the first speaker (as H does in

this sequence). Lubinski et al (1980) coined the phrase “hint and guess” to describe the process of partners offering specific lexical items as candidate repairs. In this sequence, trouble has been resolved and intersubjectivity restored, with the nurse taking on the burden of the interactive “work”.

The use of strong repair to resolve trouble was noted in all the conversations. Very often, the nurses used a hypothesis to pose an interpretation of the aphasic’s potentially troublesome turn.

- 95 TR: how do you go to the toilet?
 96 D: mm (0.2) ((taps air above head))
 97 → TR: the bell?
 98 D: ((nods))
 99 TR: that’s fine that’s fine (.) and the nurses come [and take you to the toilet=
 100 D: [mm ((nods))]

TR’s open-ended question in 95 (“how do you go to the toilet?”) is answered non-verbally by D (her gesture in 96 involves jabbing the air in the space above her left shoulder with her fingers held together, which conveys both the notion of pressing a button, and the location of the bell in relation to her bed). TR offers a candidate hypothesis in 97 (“the bell?”), which is accepted (D nods in 98). TR’s action of posing an interpretation changes the nature of the task set before D – instead of attempting to answer an open-ended question, she must merely accept or reject. This is the strategic reason why strong repair is preferable in aphasic conversation – unlike the use of weaker repair, such as a request for repetition, strong repair (paraphrases and hypotheses) makes fewer linguistic demands on the aphasic person.

Use of strong repair can be a powerful means of eliminating trouble from a conversation.

- 181 SS: And uh (0.7) how do you find your stay here at the Booth?
 182 A: h- Sorry?
 183 SS: How do you find your stay here at the Booth, (0.5) you know?
 184 A: (1) u::m
 ((looks up))
 185 → SS: I know the first, I know the first (.) couple of days you just wanted to go home
 186 A: yow=
 ((nod))
 187 → SS: =but now it’s it’s [it’s better now h[ey?
 188 A: [ye:s [ye:s

A's response in 184, as she attempts to answer SS's question, gives an indication that her contribution is potentially troublesome – she hesitates, lifts her gaze, and produces a prolonged “um”. Schegloff (1984a) refers to this type of action as a “harbinger of trouble”, an indication that repair is about to become necessary. SS responds by providing a hypothesis that is phrased as a rhetorical question (185/187 – “I know the first couple of days you just wanted to go home, but now it's better, hey?”), which A confirms (186 and 188). Trouble has been averted, and the participants are agreeing with one another.

These examples show how the nurses could use strong repair or guessing to move the conversation through troublesome patches without too much difficulty. In any conversation, participants will generally make repair trajectory is normally as quick as possible, to minimize “time out” from the conversation (Wilkinson, 1999). In aphasic conversation, strong forms of repair have the potential to quickly end trouble, as they pinpoint its source, resulting in the least collaborative effort being required to resolve trouble (Clark and Schaefer, 1987). Less collaborative effort is needed if the unimpaired partner takes on the load of repair work. By using strong repair, trouble is resolved quickly and not brought too close to the surface of the conversation.

Thus, the goal of transaction (information exchange) is protected in the conversation, as well as the goal of interaction (social solidarity), as the nurses carry out repair as quickly as possible in a manner that does not explicitly refer to a need for correction. This helped the aphasic to maintain face in the interaction, although in many cases they actually contributed very little to the conversation.

3.1.2. Interruptive strong repair

A variation on the use of strong repair was noted when nurses interrupted the aphasic participant mid-turn to execute swift, effective repair - thus prematurely curtailing the aphasic's turn. While talk often overlaps in conversation, a true interruption occurs before a TRP (transition relevance place), and will usually result in premature stopping of talk, as a repair mechanism for this organizational problem (i.e. overlap) (Sacks et al 1974). Thus, by interrupting, the nurses were able to reclaim the conversational floor, and use it to resolve trouble in the sequence. There are several examples in the data of nurses wresting the floor away from the aphasic in order to execute repair.

- 34 SF: And how did you hurt your arm?
 ((touches H's arm))
 35 H: (en[e] ((looking at arm, pointing)) (ene en[oor-)
 36 → SF: [Hmm? [You fell?
 37 H: (0.3) mm
 ((looks up))
 38 SF: Where
 39 H: (ene [oor-)
 ((looking at arm))
 40 → SF: [at home
 41 H: mm
 ((looks up))

The same process occurs twice in this sequence: that of SF cutting H's contributions short in the process of resolving trouble. To look at the first example: in 34, SF asks a question ("how did you hurt your arm?"), which H begins to respond to, using both verbalization and gesture. The first sign that H's contribution is problematic occurs with SF's general request for clarification ("hmm?") in 36, and then almost immediately thereafter with SF's stronger repair ("you fell?"). This guess has the effect of cutting off H's contribution, and resolving the trouble (H affirms SF's guess in 37). An almost identical process occurs in lines 38 to 41 ("at home"). In both instances SF is interrupting H mid-utterance, before she has reached a TRP. H had control of the floor not only because she was talking, but also because her gaze was away from SF. She had not provided any sign that her turn was over. Laasko and Klippi (1999) noted how aphasic participants who were searching for a word in conversation could invite their partner to collaborate in the search (using eye gaze, pauses, additional talk). This invitation is lacking from the sequence here – H has not oriented to trouble in her own contribution. SF's use of interruptive strong repair, however, allows both participants to reach an agreed-upon conclusion more quickly. SF's repair has the effect of curtailing H's turn - H stops mid-utterance to confirm SF's hypotheses, thus abandoning her contribution to the conversation.

A very similar pattern is shown here in case 3.

- 41 AR: =Is the boy the eldest?
 42 G: (2) ((sigh)) (1) no, x[-
 ((shake head))
 43 → AR: [In between
 ((middle gesture))
 44 G: ((nod))
 45 AR: OK.

... eliciting a confirmation instead (220 – “mm” with understanding (RC paraphrases in 221 – “oh, you fell down”) and a potentially troublesome contribution has been made.

- ... eliciting a confirmation instead (220 – “mm” with understanding (RC paraphrases in 221 – “oh, you fell down”) and a potentially troublesome contribution has been made.

369 LV: But sometimes I must listen carefully what you say.

As above, this is an example of aphasic-initiated topic change, from case 6. S holds the floor in the first part of the sequence (“I can’t... I try to...”), with LV taking the role of listener. In 363, however, LV uses a gap in S’s utterance to interrupt and provide an interpretation (“You’re trying but you are, but I can hear some...things you’re saying”), which curtails S’s turn. The remainder of the sequence is an extended turn from LV, with S now in the role of listener, providing minimal agreement tokens. Lesser and Milroy (1993) point out how aphasic participants are more vulnerable to the loss of the floor in conversation, due to their tendency to hesitate and diminished verbal output. The transition in this sequence is quite noticeable: LV is able to regain the floor, as she has superior linguistic resources. As Sacks et al (1974) predict, errors in the turn-taking system, such as overlapping speech, are repaired by one speaker ceasing their talk – and in these cases, it is usually the aphasic who stops talking.

Interruptions of this type were noted fairly often in the data (although not in all cases). This contrasts to Schegloff et al’s (1977) assertion that others invariably “withhold” repair initiations while the trouble-source turn is in progress. It contrasts also to Wilkinson’s (1995) observation that some partners of aphasics may delay possible other-repair in order to give the aphasic a chance to repair themselves. These withholding behaviours are supposed to reflect the preference for self-repair in conversation as a more “face-saving” strategy. However, the nurse’s interruptions in this data serve to limit trouble rather than expose it, thus minimizing the interactive consequences of the aphasic’s linguistic difficulties. Invariably, the nurses are interrupting to attempt repair or offer a hypothesis. Oeschlaeger and Damico (1998) describe how joint productions occur in aphasic conversation, as a way to enhance communicative effectiveness and efficiency, as the partner is sharing conversational responsibility or burden. It is a very collaborative way of managing a conversation. As other-repair is so frequently needed in aphasic conversation, this may become a more acceptable, less face-threatening resource.

It is noted here, however, that the nurses could be somewhat aggressive in offering repair. Interruption serves to limit potential trouble by curtailing aphasic’s contributions – with less floor-time, aphasics have less chance to produce problematic turns. Although this interruptive repair is a facilitative strategy, there is an element of conversational bullying about it – the nurses can exercise their superior linguistic resources to control the interaction. This pattern

3.1.3. Simplifying the task

- 1) switching from an open-ended question to a close-ended one
- 2) giving the aphasic alternatives from which to choose
- 3) encouraging non-verbal modalities.

92 SF: What- (0.6) ooh, how am I going to do this- what work did you do (0.6) when
you were young?
93 (2)
94 → SF: di- did you work?
95 H: mm
(nods)

A second method of simplifying the task for the aphasic partner was to provide them with options, as demonstrated in case 1 again below. SF has been asking H about when she will go back to hospital to have her arm x-rayed.

298 SF: which hospital
 299 H: (en mo)
 300 (0.6)
 301 → SF: where (.) Groote Schuur (.) Somerset
 302 H: o:h (.) (en mo)
 303 (1)
 304 SF: Groote Schuur?
 305 H: mm
 ((nods))
 306 SF: OK

SF indicates trouble in 301 by repeating her question in part (“where”), and then starts to provide some candidate alternatives. Her strategy is however unsuccessful – H’s response is still unintelligible. SF then makes a guess in 303 (“Groote Schuur?”), which elicits a confirmation. Here, a procession of strategies from most- to least linguistically demanding is used to elicit a satisfactory response from H, allowing the sequence to close on a note of agreement.

Encouragement of non-verbal modalities to provide answers was also noted in several cases, especially where the projected answer was numerical.

20 AR: And tell me Mrs: Gallant, (0.5) u:m how many children have you got.
 21 G: I got- (1)
 ((head to side))
 22 → AR: You can show me with your fingers if you like?
 ((holds up 10 fingers))
 23 G: (2)
 ((shows three fingers))
 24 AR: Three.
 ((three fingers))
 25 G: ((nod))

G is giving signs that her response may be problematic in 21 (pausing). AR intervenes in 22 to prompt G to switch to an easier non-verbal strategy (“you can show me with your fingers if you like”). G immediately uses this, abandoning her potentially troublesome utterance, and allowing AR to produce a paraphrase to confirm. Here again, a strategy of simplifying the linguistic demands of the task is again successful in gaining an acceptable answer. Simmons-Mackie and Kagan (1999) identified accommodation to aphasic’s style of communication (e.g. non-verbal) as a feature of “good” conversation partner – although here, the partner is imposing rather than accommodating. G is not given much chance to produce an answer in a

modality of her own choosing, and AR's eagerness in offering help can be seen as condescending.

These examples demonstrate again how the nurses appeared to be sensitive to the presence and the potential for trouble in the conversations, and were able to effectively limit it by presenting the aphasic with a less linguistically-demanding task. Questions could thus be answered without trouble, and associated embarrassment. This strategy served in most cases to protect both transaction and interaction – although in some examples, information exchange could be compromised, and possible condescension implied.

3.1.4. Agreement sequences

As reflected in many of the extracts above, episodes of trouble were regularly followed by sequences of intensified agreement. A few more examples can illustrate this further.

Here is a straightforward example from case 3, which follows some preceding trouble regarding the number of G's children.

- 35 AR: And how many are girls?
36 G: (0.5) um sh[m-
37 AR: [Show me [with your fingers
 ((three fingers))
38 G: [((three fingers))
39 → AR: Three girls. [(.) So it's one boy[and three girls[.=
40 G: [((nod)) [((nod)) [((nod))

AR reflects G's non-verbal contribution (38 - showing three fingers) verbally in 39 ("three girls"), allowing the aphasic to confirm the nurse's understanding. AR's next action in 39 is to repeat already-established information ("so it's one boy and three girls"), predictably eliciting further agreements from G. This allows a troublesome sequence to end in a clear display of resolution and intersubjectivity. Clark and Schaefer (1987, 1989) stress how participants in a conversation have an obligation to establish and display mutual understanding, which AR is doing here very explicitly.

The extract below, from case 4, also follows a long episode of trouble, an extended sequence on the topic of A's children's ages, with SS using various types of repair to resolve the difficulty. A is using gesture to answer in 71.

71 A: fi:ve and ((shows one finger))
 72 SS: Six?
 ((shows six fingers))
 73 A: yes
 ((nod))
 74 → SS: six years=
 75 A: =yes
 ((nod))
 76 → SS: is that the baby?
 77 A: yes
 ((nod))
 78 → SS: So she's going to (.) preschool
 79 A: yes
 ((nod))
 80 → SS: oh I see, (.) and the the eldest one is in standard six
 81 A: yes. fourteen=
 82 → SS: =she's fourteen years old.=
 83 A: =yes

SS poses a hypothesis in 72 ("six?"), which is accepted by A. SS then presents five consecutive contributions (74, 76, 78, 80 and 82), which all reflect information that has already been established in the interaction. This allows for a rapid sequence consisting entirely of agreement to close the topic, strongly affirming that intersubjectivity has been reached.

Finally, an explicit indication that understanding has been reached, from case 5, following an extended problematic turn from W.

258 W: And then, when I got through, (.)
 259 W: then I (had to go back), (x x) (eventually) (x xx,) and now I'm (xx.)
 260 → RC: O:h, so you, so you went through.
 261 W: Yes
 262 → RC: So you went through the, the the- sickness.
 263 W: Yes
 264 → RC: Ah, so you better now.
 265 W: Yes
 266 → RC: A::h, (.) now I understand. ((laugh)) now I understand
 267 W: ((laugh))

RC poses hypotheses with increasing confidence in 260, 262 and 264, shifting control of the floor back to herself and eliciting a string of agreements from W. Her contribution in 266 ("Ah, now I understand") is an explicit display of acceptance and comprehension, and the sequence can again end with a very clear impression of agreement.

Several other authors have noticed similar phenomenon in aphasic conversation. Milroy and Perkins (1992) observed reciprocal exchanges of acknowledgement tokens after lengthy repair sequences: they propose that long, complex and potentially confusing repair sequences need to be closed down in such a way as to re-assure interlocutors that the hearer has reached the intended understanding. Laasko and Klippi (1999) also noted a prolonged confirmation phase after trouble, with both participants giving acknowledgement tokens. Simmons-Mackie and Kagan (1999) suggest that the clarification sequences that form part of repair could act as a face saving device, allowing participants to finish on a note of agreement even when trouble was not fully resolved. This reinforces the impression of affiliation, which is important to regain after trouble.

The observable results of the nurses constructing these agreement sequences were that predictable agreements were elicited from the aphasic participants. This is a strategy that promotes interaction, as it ensures agreement and a smooth flow of conversation. The placement of these sequences after trouble again reflects the nurse's efforts to minimize the interactive consequences of repair, by emphasizing a display of understanding.

3.1.5. Repeated confirmation

Interestingly, similar patterns were noted when nurses gained unproblematic responses from the aphasics. It appeared that even when the potential for trouble was minimal, the nurses tended to make understanding explicit.

Here is an example of a prototypical pattern, from case 6.

- 63 LV: How many children have you got?
64 S: Three::
 ((three fingers))
65 → LV: Three
66 S: yeah
 ((nod))

Although S's response in 64 ("three", with three fingers) appears quite unproblematic in the transcript, LV's next action is to repeat S's previous turn (65 – "three"). This action of repetition is not projected by S in 64. S treats it as a request for confirmation by giving an agreement in 66 ("yeah" with a nod). LV's repetition allows her to demonstrate that she has

understood S in 64, and also to ensure that she is correct in this interpretation (S had the option of rejecting in 66).

- 84 AR: And um: when you leave hospital, (.) are you going to be going home?
85 G: ((nods))
86 → AR: You're going to be going home.
87 G: ((nods))

AR repeats the meaning of G's affirmation in 86 ("you're going to be going home"). This is not an extension of the conversation – merely, as above, a confirmation. AR has the option to produce a turn in 86 that implicitly shows understanding (for example, "oh that's nice"), but instead, she opts to give an explicit display of intersubjectivity. This sequence shows both participants collaborating in emphasizing AR's understanding of G. As above, the nurse's contribution could be considered redundant, as it reflects information that has already been explicitly presented in the interaction. However, both examples demonstrate an orientation towards ensuring and confirming intersubjectivity.

Repetition often acts as a strong repair initiator: however, repetition can also register receipt (Schegloff, 1997) and gives the first speaker an opportunity to confirm (Clark and Schaefer, 1987). What is striking in this data is the frequency with which this occurs (observed in all cases). As Schegloff (1992) points out, displays of mutual understanding are generally achieved implicitly (by being displayed in next turn). But in this data, the nurses preferred to make understanding explicit. According to Clark and Schaefer (1987), participants will work together to display understanding adequate for current purposes. In the context of aphasic conversation, it is arguably more important to show understanding (due to the high occurrence of trouble), resulting in the patterns seen here.

Summary – minimizing the effects of trouble

The nurses handling of repair in these examples show an orientation towards minimizing the interactive effects of trouble, and ensuring a clear display of understanding. They attempted to reach a swift resolution to repair, and emphasized intersubjectivity when it was achieved. These behaviours could be seen as being highly facilitative – the nurses are saving face by effecting repair as quickly as possible, and ensuring that the correct information has been transacted. However, the use of these strategies meant that the nurse took a very dominant role in the conversation, at times curtailing aphasic partners' turns and limiting their

opportunities to contribute. The aphasic partner's capability to add meaningfully to the conversation was not always revealed by this strategy.

3.2. "Glossing over" potential sources of trouble

As seen above, the nurses seemed to place a premium on displaying intersubjectivity. However, as will be shown in this section, sometimes the impression of intersubjectivity was just as acceptable. In the literature on repair in aphasic conversation, several authors have noted how the non-aphasic partner has the opportunity to "gloss over" trouble (Lindsay and Wilkinson, 1999; Lesser and Algar, 1995; Perkins 1995; Cunningham and Ward, 2003) – that is, to leave potential sources of trouble unaddressed. In this data, this trend was noted quite strongly, as shown by the examples below.

3.2.1. Paraphrase to gloss over trouble

As demonstrated above, nurses would typically make a guess as to the meaning of an aphasic's problematic utterance. The nature of these guesses as candidate repairs was indicated by the rising intonation (several authors have commented on how rising intonation reflects uncertainty - Clark and Schaefer, 1987; Schegloff et al 1977). By contrast, a paraphrase (with falling statement intonation) reflects a high level of certainty – the hearer is re-stating the speaker's meaning to demonstrate understanding (Clark and Schaefer, 1989).

The striking finding in this data was some nurses' tendency to use paraphrases on potentially very problematic utterances. This can be seen in line 157 (from case 4).

- 151 SS: U::m (0.7) how long. (0.5) when did the stroke (.) start. Is it -
152 A: o::h, um um (1.8)
153 SS: how long ago?
154 A: um (2) two::: um two:
((shows two fingers))
155 SS: two weeks?
156 A: ss- ss-
((shows four fingers))
157 → SS: so it's four weeks now.=
158 A: =yes

In 155, SS produces a hypothesis based on the information given by A in 154 (both verbally and gesturally) in a request for confirmation ("two weeks?"). A however does not provide acceptance in 156, instead altering her answer (showing four fingers). SS does not repeat her

previous construction of requesting confirmation for this new contribution – instead, she produces a confidently-phrased statement (“so it’s four weeks now”). 157 is no less a hypothesis than 155 is – yet SS presents it as an established understanding rather than a candidate understanding. This increases the impression of intersubjectivity and decreases the appearance of trouble. While A still has the option to reject it, SS’s interpretation is phrased as a foregone conclusion.

In the example below, a paraphrase is used to curtail trouble.

- 72 AR: =Is your husband still[alive.
 73 G: (1) (0.5)(1) (xx)[-
 [((nodding)) ((waves hand back))
 74 → AR: [passed away.
 75 G: ((nod))

This sequence follows some trouble – AR has ascertained that G is married, but G is attempting to continue, indicating some sort of repair or clarification is necessary. G attempts some further elaboration in 73 (waving her hand back, some verbalization), unintelligibly, and AR interrupts in 74 with a paraphrase (“passed away”) that reflects a possible interpretation of G’s gesture. Again, AR’s contribution is essentially a hypothesis, but it is phrased with more certainty, avoiding a further display of trouble.

- 139 TR: OK so will there be someone who’s going to look after you at home?
 140 D: ((nod))(s:)((point to self))
 141 → TR: Your sister.
 142 D: mm
 ((nod))
 143 TR: O::K: OK that’s fine (.) OK

TR’s question in 139 is a close-ended one, but D appears to elaborate on her answer in 140 (some attempt at speech, pointing to herself). TR resolves this potential source of trouble by providing a candidate hypothesis, phrased as a statement (141 - “your sister”). It is unclear in the transcript whether she is basing this on D’s verbal production, her gestures, previous information in the conversation, prior knowledge, or if it is merely a guess. Either way, TR expresses her hypothesis confidently. One effect of this is to cast TR’s contribution as adequate – by using a less explicit form of repair, TR can create the impression of conversational competence.

RC in case five was especially adept at producing confidently-phrased hypotheses on the most dubious information.

- 1 RC: So:, (.) where do you stay Mrs Walton?
 2 W: I stay in (my a) (.) (in my) (.) Wa:lto:n.
 3 → RC: (1.5) O:h, in your hou:se. Is it a small house?
 4 W: (0.8) a=
 5 RC: =Or just a flat?
 6 W: yes
 ((nodding))

W's answer in 2 seems at the outset to be appropriately-phrased, but ends in error ("I stay in my Walton"). RC's pause in 3 indicates that something troublesome has occurred.

Nevertheless, in 3 she first offers a sign of understanding (prolonged "oh"), and then a confirming statement ("in your house"). Especially in this instance, it is unclear what she bases this understanding on. The content of 3 does not follow from 2. What RC appears to be doing is posing a hypothesis, phrased as a confirmation. This projects for W's turn to be acknowledged and ended so that the conversation can continue, with no indication of trouble. This pattern recurs repeatedly in case 5.

RC's hypotheses were quite frequently rejected, as happens in 40 below.

- 38 W: =I'm now, I'm of (.) (three: months), I'm now, three months.
 39 → RC: Three months in the flat. (x)-
 40 W: no no, (x, xx) (.) (it sit) (0.5) wha:t's i:n (0.8)
 ((pointing finger))
 41 RC: [u:h
 42 W: [(x xx), then I took.
 ((pointing finger)) ((nod))
 43 RC: O::h
 44 W: then I took (my ride). x x ((laugh))
 45 → RC: O:h, then you took your ride.
 46 W: ((laughing))

In 45, after a protracted troublesome turn from W, RC reflects an intelligible fragment of W's talk as a confirming statement ("oh, then you took your ride") – even though in this makes little sense in the context of the conversation (W's response in 46 is to laugh!). It is certainly arguable that RC is feigning understanding in order to minimize trouble and move the conversation on.

A paraphrase is a commonly-observed behaviour in talk. Both Clark and Schaefer (1987) and Schegloff (1992) identify it as a distinct type of utterance overtly designed to check the speaker's understanding of preceding talk. Milroy and Perkins (1992) identify paraphrasing as a particularly useful repair strategy in aphasic conversation, as it reflects the hearer's state of understanding, and if correct, no further repair is required (only an acknowledgement token is needed) – thus the least collaborative effort is used. Lindsay and Wilkinson (1999) show how paraphrasing can curtail repair: it is designed to elicit agreement, and often the speaker will accept an approximation of the target rather than the target itself.

Using a paraphrase rather than a request for confirmation subtly casts that aphasic partner as a more competent communicator. The nurse treats the aphasic's contribution as if it has been understood, but still offers her interpretation for confirmation. By using a statement rather than a guessing form of a hypothesis, the nurses can convey a stronger sense of certainty, and project an agreement as the preferred answer. Although the aphasic's production may be visibly problematic, the participants are hardly showing trouble - this creates the impression of communicative competence.

In the aphasia literature, this kind of behaviour is viewed positively. Bryan et al (1998) show how a facilitative partner rephrases aphasic's communication attempts into specifics, and responds to and expands the communicative intent. Lesser & Algar (1995) attributed fewer breakdowns to partners being able to paraphrase the aphasic person's turns rather than seek repair. Simmons-Mackie and Kagan (1999, p 813) saw good partners as demonstrating affiliation and trust in the sincerity of aphasic's offering – “even when utterances are bizarre or seemingly incomprehensible.”

However, as implied in some of the examples above, this strategy can also be used to feign¹ understanding in some contexts, and thus curtail troublesome turns. While interaction may be

¹ Note on “feigning”: In CA, analysis should be based on the *observable* conduct of the participants. The analyst is not supposed to speculate upon what the interactants hypothetically or imaginably understood. This means that it becomes methodologically difficult to assume that a participant did not understand, when they have displayed that they did. Heritage and Atkinson (1984, p 11), however, make a relevant comment on this issue: “Although the value of sequential analysis in getting at the participant's understanding of the talk has been stressed... it should not be concluded that the way in which a speaker responds to a prior utterance can, in every case, be treated as criterial in determining how an utterance should be viewed analytically. Obviously, speakers may respond to earlier talk so as to avoid taking up and dealing with what they perfectly well know it accomplishes or implicates, and, by these means, may negotiate the direction of talk away from an undesired outcome or towards a desired one. Such occasions are common in talk, and may be varyingly transparent to

preserved and promoted, transaction may be sacrificed. Although face is saved, no real respect for the aphasic partner's attempt at contributing is implied.

3.2.2. Continuing with next relevant turn

In a rather contrasting pattern, in some cases nurses treated potentially troublesome contributions in a way that did not orient to them being problematic at all. This was accomplished by producing next-turns that appeared to imply understanding of the aphasic partner's contribution, by continuing with a meaningful, related contribution. Initiating a next contribution presupposes full understanding of the previous turn, and the next turn at talk will implicitly display the hearer's interpretation (Heritage and Atkinson, 1984; Clark and Schaefer, 1987). This is a typical structure in normal conversation – however, what was notable here were cases of nurses continuing with a next relevant turn at times when it appeared they had not fully understood.

- 228 SS: ((gets up)) ((squeezes A's hand))
229 A: no no no?
((points to tape recorder))
230 → SS: No, I'm finished, I'm going to (0.5) call, alright?
231 A: Ye:s (0.7) no no ((turns off tape recorder))

A seems to be asking whether the tape should be turned off in 229 ("no no no?" - an interpretation bourn out by her action in 231, of turning the tape off). This is a potentially troublesome contribution, and SS has the option of initiating repair (e.g. "do you want to talk more? should I turn the tape off?"). Instead, SS implicitly signals that she has understood A's meaning by responding to her in 230 ("no, I'm finished, I'm going to call, alright?"). Whether her interpretation is correct is dubious – this is more of an avoiding, placating response. SS manages here to avoid having to indicate or repair trouble.

In another rather unconvincing example from case 5, RC is commenting on how young W looks for her age.

- 175 RC: Your face, your face=
176 W: =yes, (of course) (x xx [x] (there and there:), but otherwise (xxxx x xxxx [x.)
((points to face)) ((nods))

analytic inspection." This can be applied to the situation here, where a transcriber can be varyingly sure how much a nurse could have understood of the previous turn.

177 RC: [just for the- [ja:
 178 → RC: Ja², you can't notice it so
 179 W: (0.3) yes=
 180 → RC: =ja:, you can't notice it. You can see (.) little [bit.
 181 W: [ye:s=

W gives some expansion and/or clarification in 176, in another long, problematic turn. RC's assessment once W has ended her turn in 178 ("you can't notice it so") implies understanding of the previous turn, although what this is based on is uncertain. W nevertheless accepts this contribution as unproblematic (179 – "yes"), implying that 178 makes sense in the sequential context. Having gained agreement, RC continues in the same vein, using a rhetorical statement again (180). As noted above, nurses may be feigning understanding at times.

One of the features of the turn-taking system is that a speaker has to construct a turn in such a way that the hearer knows what kind of response is implicated (Sacks et al 1974). What seems to happen in the example above is that the nurse recognizes the type of response required, even without fully comprehending the initial contribution. This allows the opportunity to feign understanding.

This pattern was notable by its absence – it occurred only five times (feigned or otherwise) in the entire set of data. The nurses generally tended to make understanding into an explicit display where they could. However, both of these strategies demonstrate the nurses' orientation towards creating an impression of intersubjectivity. In this particular example, interaction is again preserved at the expense of transaction.

3.2.3. Summarizing previous information

Another way to curtail troublesome turns in a display of understanding was to return to a previous contribution by means of a summary, as demonstrated in case 3 below.

88 AR: And who's gonna- (.) do you stay on your own,
 89 or do you stay with one[of the children?
 90 G: [a-
 91 G: hhh (2) my daughter stay- (.) a[
 ((waves hand))
 92 AR: [with your daughter.
 93 G: and- e-e-r, (x x xx x) (1.5) well I (x x xx xx)

² Translation: "Ja" is Afrikaans for "yes", and is commonly used in South African English.

- 94 → AR: So is your daughter [going to look after you. (1) OK.
 ((nod))
 95 G: [((nod))

G provides a partial intelligible answer in 91 (“my daughter stay”), which AR interrupts to confirm in 92 (“with your daughter”), cutting off G’s turn and any further potential trouble. Here again is a paraphrase. G does not reject this, but attempts to elaborate in 93, very unintelligibly. Once G has reached a TRP, AR is obliged to contribute, either with further repair or acceptance. AR responds by repeating the information she has hypothesised so far (94 - “so is your daughter going to look after you”), and glosses over the content of 93. This strategy avoids having to explicitly reveal trouble, and projects an agreement response from G. It allows the sequence to end in mutual agreement, even though much of what G has contributed has not been fully acknowledged or resolved.

This happens more explicitly in case 5 – having ascertained W’s age earlier, and then her daughter’s age, RC is commenting on the gap between them, and asks whether W married late. W rejects this idea.

- 196 RC: So you were, [(1) still in your twenties?
 197 W: [yes
 198 W: (2) oh yes, I was in (x x x), in (x x) (.) forty (0.6) five.
 199 RC: (0.8) O:h, forty five
 200 W: (x), ('cos I was, 'cos I was) twenty
 201 RC: mm?
 202 W and I (x) (nineteen forty five).
 203 → RC: Oh now you eighty three. (.) O:h I see.

In 199 (“oh, forty five”) RC confirms an audible fragment by repetition to indicate understanding (although what she really understands is debatable). W continues, but RC indicates trouble by requesting repetition/clarification (201 – “mm?”). W continues in 202 (“and I... nineteen forty five), finishing her turn, and thus obligating RC to take the floor. RC responds by repeating information that she already knows (203 - “oh now you eighty three”). This returns the conversation to safe ground – W is guaranteed to accept RC’s contribution, and RC is excused of having to repair W’s troublesome turns.

- 178 S: It’s my birth(day) (.) next month
 179 LV: next month
 180 S: Ja:.

181 LV: January
182 S: Ja.:
183 LV: (0.6) what date?
184 S: (1) no:, [x x xx x
((shaking head))
185 → LV: [can't remember the date, but it's (.) January
186 S: mm:
187 (2.5)
188 → LV: Fifty nine, huh? And you three children.
189 S: Ja.:

This sequence follows a long stretch of trouble (regarding S's age). In 183 LV asks a question ("what date?"). S explicitly shows that she will struggle to answer this question in 184 (shaking her head), and LV cuts her off by interrupting in 185. LV recognizes S's difficulty ("can't remember the date"), and repeats what has already been ascertained ("but it's January") so that the sequence ends on a note of agreement. LV continues to re-state what is already known (188 – "fifty nine, huh? and you three children"), possibly trying to avoid any further trouble after a long disaffiliative sequence.

This pattern occurred particularly in case 5, where the aphasic partner was quite verbose.

282 W: Yes, well I had a lot of (forf), (x), you know,
((showing arm))

283 RC: [(x x)-
(nod)]

284 W: [(xx x) and I had a fall in (x,) in (x,) oh I don't know,

285 RC: mm

286 W: and then I was (x, xxx, xx x,) the whole thing (happened) so quickly.

287 → RC: (alright), so you went very sick.

288 W: yes

Again here in 287 RC ends a problematic sequence by re-presenting information that is already known from previous talk (“so you went very sick”). RC is not explicitly indicating that trouble is occurring, but is making a contribution that is guaranteed to be trouble-free.

This pattern is another example of nurses curtailing repair, by producing a contribution that is designed to elicit agreement (as summarizing is designed to do - Lindsay and Wilkinson, 1999). Wilkinson (1999) points out how the sequential context of the conversation can be used as a resource for achieving intersubjectivity – here, the nurses are using previous information in the conversation to minimize trouble and repair. It can be used to gloss over a

troublesome turn, thus sacrificing transaction, but ensures agreement between participants, which promotes interaction.

3.2.4. Minimal tokens

An even simpler way for nurses to avoid responsibility for displaying understanding was to use minimal tokens, such as “mm” “OK” or “oh”. These are examples of discourse markers, expressions used to organize conversational interaction and regulate the flow of interpersonal interaction (Schriffin, 1987). As discourse markers are commonly tokens of reciprocity, they play a central role in the process of displaying positive evidence of understanding (Clark and Schaefer, 1987). Minimal tokens have various functions depending on their sequential placement, including acknowledgement, continuers (Jefferson, 1984a), and understanding claims (Schegloff, 1982) in that the recipient has declined an opportunity to initiate repair on the turn, and by implication, that they have understood so far. Heritage (1984) notes that such tokens are entirely opaque regarding the quality or character of the change of state proposedly undergone by their performer, in that they give no evidence of understanding. Nevertheless, they mark a “strong” reciprocity, in Heritage’s terms.

The use of such markers is common enough, but the interesting pattern noted in this data the nurses’ use of these discourse markers at times when it was very doubtful as to whether the aphasic partners’ contributions were intelligible to them. Consider what D bases her acknowledgment on below (57).

- 56 TR: OK have you got a lot of family?
57 D: ((shakes head)) hh ((nods)) ((points to self))
58 → TR: O:K
((nod))

D’s turn in 57 is complicated in the transcription – she shakes her head, nods, gestures and vocalizes. TR however does not initiate any repair or indicate that any trouble has occurred in 58, responding instead with a prolonged “OK”. What does “OK” mean here? It is an acknowledgement token, a positive one, but a non-committal one. It implies hearing, but does not necessitate understanding. This resonates with a significant omission in this particular conversation – TR’s lack of explicit displays of understanding (e.g. summaries, further expansion). While TR tended to treat D’s contributions as trouble-free and acceptable, she gives no other sign that D has added something meaningful to the conversation. Schriffin

(1987) notes how “OK” marks transitions for one activity to another – and TR does in fact move on to the next question.

Non-specific acknowledgers were often found after a sequence of trouble and repair. In case 6, LV has asked S how she feels, and gains an unexpectedly problematic response. In 10, she is attempting to recast her question.

- 10 LV: I-I don't mean, u:h, how do you feel about your, (.) uh pain or anything,
11 LV: I mean how do you feel about-=
12 S: =(xx) (so:re, [(.) sore.)
((arm forward))
13 LV: [mm
14 → LV: o::[h
((nods))
15 S: [mm:: (0.7) xx x:, (I kno:w), x xx (1) x:.
16 LV: Before you came here, (.)

LV is trying to effect repair in 10/11 (“I don’t mean how you feel about your pain...”), but S seems to wish to attempt her own repair, and interrupts in 12 (“sore, sore”) to give a further contribution. LV yields the floor to her, providing an encouraging acknower in 13 (“mm”). When S reaches a TRP, LV responds with another acknower in 14 (prolonged “oh”), one that strongly implies understanding (Heritage, 1984), but displays no explicit confirmation of meaning. This allows the sequence to end, as S brings up a new topic in 16 (note how no acknowledgement of 15 is given). It is worth noting here that “oh” is scarcely ever continuative, as it implies that the hearer has understood (Heritage, 1984) – here, the nurse uses it to close a sequence on a display of understanding – although S’s meaning is obscure in the transcript.

A whole series of non-specific acknowledgers occurs in the sequence below:

- 243 RC: = Oh hje:ne³. So you haven't got other friends in the, in the hospital here.
244 W: (no)
((shakes head))
245 RC: You don't know anybody now here.
246 W: (.) O::h, oh there's quite a, quite (a number) (x x).
((waves hand out)) ((nodding))
247 → RC: O::h.
248 W: (xx, xx xxx.)

³ Translation from Afrikaans: “heavens”

- 249 → RC: oh
 250 W: I, (.) (xx xx xx,) well, I know, (x xx) I: (.) (xx x. x x:., x x x:.)
 251 W: (x x x x xx x:) (and they all and they right up where they (xxx,) they were there
 ((gesturing up))
 252 W: and they all (xxx.)
 253 → RC: o::h.

W unexpectedly rejects RC's summary (245 – “you don't know anybody here”) in 246 (“oh, there's quite a number”), and goes on to produce several more potentially-troublesome turns (248, 250-252). RC gives a minimal token after each TRP (“oh” in 247, 249 and 253). These are typical vague acknowledgers, implying understanding but not displaying it. In this way, RC moves the conversation through a troublesome patch without any overt sign of difficulty. The potential trouble is not brought to the surface.

Despite the hearable error in the aphasic partner's productions, in these examples the conversations continued without repair. This could occur because participants implicitly assume that they are understanding each other and achieving intersubjectivity until one of them displays otherwise through the initiation of repair (Heritage and Atkinson, 1984). Using tokens that imply understanding thus allowed the nurses to assert intersubjectivity without having to display it.

Simmons-Mackie and Kagan (1999) view such tokens positively, as they typically informed the partner with aphasia that the volunteer was listening and interested in the contribution. In the present study, the use of these tokens is more concerning, as again they seemed to be a device for feigning understanding and avoiding trouble. This is reminiscent of Jefferson's (1984a) term “perverse passive”, where one participant exploits the use of acknowledgement tokens to avoid speakership. A display of passive reciprocity can elicit further talk, allowing the user to abscond the obligation to speak.

Acknowledgement tokens proliferated the conversations. Their use allowed the nurses to close troublesome topics in a manner that implied they had been resolved, without having to offer any proof of understanding. This avoided the occurrence of trouble and the necessity for repair. The aphasic's turns were not revealed as being problematic – thus, the impression of communicative competence is maintained, even though it may not be genuine. Interaction is superficially maintained, but transaction may be very compromised.

3.2.5. Topic shift

Yet another pattern that demonstrated how the nurses were able to avoid potential sources of trouble was topic shift. In some instances, nurses were able to introduce new topics during episodes of trouble, acting as a device to move the conversation on, leaving the potential source of trouble unacknowledged or repaired.

- 187 SS: =but now it's it's [it's better now h[ey?
188 A: [ye:s [ye:s
((nod)) ((nod))
189 SS: is it better
190 A: yes yoo:w um (0.5) for (1.2) for[
191 SS: [mm=
192 → SS: =and your family, they they come and visit you every[.] day now
193 A: [ye:s yes

This extract, from case 4, comes at the end of a sequence where SS has carried out repair (187 - “it’s better now, hey?”) and A has confirmed it (188 - “yes”). In 190 A begins to attempt a problematic expansion (“yes, yow um, for, for...”), but SS cuts her off with a non-specific acknowledger (“mm”) before launching into another topic (192 - “and your family, they come and visit you every day now”). A responds in 193 (“yes”), her problematic attempt at contribution to the conversation having been cut off with no acknowledgement from SS. Here, topic shift can be seen to act as a trouble-avoiding device – SS uses it to move A away from a potentially troublesome contribution.

- 297 LV: Can you dress yourself?
298 S: (1) Half.
299 LV: Half. Everything is half.
300 S: Just half. (x:, xx x[xxx x.)[
((points to lame arm and leg))
301 LV: [mm [mm
((nods))
302 S: (xx x: xx xx[x-)
303 → LV: [Now who’s going to look after you at home?
304 S: ((looks at LV))

LV appears to be closing the sequence in 301 (acknowledging and nodding). When S produces an unsolicited (and problematic) contribution in 302, LV interrupts with a topic change (303 - “now who’s going to look after you?”) that returns the floor, and control of the conversation, to herself. Again, the aphasic abandons her own contribution and attends to the topic the nurse has introduced.

262 LV: How do you like to stay with Mrs Adams, she's a nice lady, hey?
 263 S: Nah (x)
 ((dismissive gesture))
 264 LV: Mm?
 265 S: (2) (ghost)
 266 LV: Mm.
 267 S: (x::, x xx.)
 268 → LV: But your hair looks lovely
 269 S: hm?
 ((touches hair))

LV does not receive a preferred or expected answer to her question in 262 ("How do you like to stay with Mrs Adams, she's a nice lady, hey?"), but S's explanations are short and problematic. Rather than pursue the potential trouble, LV simply acknowledges in 266 ("mm" - see discussion of non-explicit acknowledgers above). S continues in 267, with a contemptuous tone, but no more intelligibly. LV does not acknowledge this turn - instead, she moves away from potential trouble with a change of topic (268 - "but your hair looks lovely"). This topic then continues. Again, LV has successfully closed a troublesome sequence with little display of trouble.

A subtler example from case 3:

102 AR: And were you quite happy [here at Booth Memorial Hospital?
 103 G: (((nod))
 104 G: ((inclines head to side)) (xx xx)
 105 → AR: Yes. But I'm sure Kate is helping you with your speech, hey
 ((smiles))
 106 G: ((nods)) (yes)

G's answer in 104 is difficult to interpret in the transcript, especially in terms of whether it is positive or negative. AR seems to treat it as a positive, smiling in her acknowledgement (105 - "yes"), although no explicit sign of understanding is given. She then moves the conversation away from this potential source of trouble by shifting topic (105 - "but I'm sure Kate is helping you with your speech, hey"). It is impossible to tell whether AR understands G's turn in 104, as she has avoided the obligation to display intersubjectivity.

151 W: And (x x::) I- I haven't got a (mother),
 152 RC: mm.
 153 W: (x x x::) (I'm an old lady) (1) and I- (chose) (xx)- (0.6) (what) (x,) ((laughs))
 154 → RC: Ja but you haven't got a mother you say.

155 W: (([laughing]))
 156 RC: [But your children got a mother,=
 157 W: ye:s
 158 RC: y[:ou see?
 159 W: [oh ye:s ye:s.
 160 RC: They are lucky, ye:s, they are lucky they still got a mother.
 161 W: yes.
 162 RC: Ne⁴? And the mother went through a lot of things
 163 W: Ye:s

W's contribution in 151 ("I haven't got a mother") bore no apparent relation to previous talk. Once RC was obliged to take the floor, she returned to this intelligible, although confusing, fragment ("you haven't got a mother, you say"), and worked it into a meaningful comment (156 – "but your children got a mother"), thus moving the conversation through a problematic sequence without trouble. This is what Sacks (in Jefferson, 1984b) calls a stepwise transition of topic, as opposed to the more abrupt, boundaried topic changes seen before. Jefferson (1984b) describes how one accomplishes this, by a combination of summing up the topic, and then turning to matters that are ancillary to the topic, which constitutes a recognizable movement away from trouble.

Sacks (cited in Jefferson, 1984b) proposes that a prototypical way to get off a problematic prior topic is to specifically mark that a new topic is going to be started. This was reflected in the data here by the use of pre-shift markers like "but", "and", "ja" and "now". Jefferson (1984b) also notes that exit devices can be characterized by interactional cohesiveness – they tend to be other-attentive, requiring some response from the partner. This feature was also noted in the data – the nurses would engage the aphasic's attention with another topic to move away from the trouble.

As seen here, topic shift could be used to avoid the obligation of having to repair a problematic contribution, and generally served to return control of the conversational floor to the nurse. Interactionally, it is a difficult move to pull off, and was managed with varying degrees of success in the examples above. However, its likely purpose was to avoid the threat to face that would be posed by the nurse showing non-comprehension of the aphasic's turn – thus, it can again be seen as a move that preserves interaction at the expense of interaction.

⁴ Translation from Afrikaans: "not so?" (dialectal marker)

A final strategy that nurses were capable of using to minimize trouble in the conversation was to openly abandon a topic. This usually occurred with some kind of assuring and placating (such as “no that’s fine”, “don’t worry”, “it’s OK”), in very blatant avoidance of trouble in the conversation.

176 AR: And do you- what is you son's name?
177 G: (3) um (1.5) (xx xx x x x x xx.)
((pointing finger from side to side))
178 AR: (0.7) Noah?
179 G: (xx xx xx xx, xx) (0.5) .
180 → AR: OK no that's fine.

In case 5 below, W is trying to explain where her daughter stays.

65 W: And the other one (stays) in, (xx,) uh-uh, (xx,) oh no (2.4) (sst) I can't=
 66 → RC: =OK OK, it's alright you can'[t-
 ((points up))
 67 W: [(x) [(x xxx)=
 68 RC: uh-huh
 69 W: =I can s:ay it,
 ((finger up))
 70 RC: uh-huh
 71 W: it's ss (0.4) ss oh no I'm=
 ((finger up)) ((shakes head))
 72 → RC: =No you don't know, OK, but no that's fine.

53

gesture. W however does not let RC end the topic, interrupting in 67 to reclaim the floor (69 – “I can say it”). RC allows this, even providing tokens of encouragement to continue in 68 and 70. W however finally gives up in 71, and RC accepts and encourages her abandonment in 72, placating and assuring W (72 - “but that’s fine”). There is some degree of face-saving happening here – RC is openly telling W that it is “alright” if she doesn’t answer the question.

- 52 TR: O:K: (0.5) where’s your husband?
 53 D: ((nods)) ((points finger down)) (sss) ((nods))
 54 → TR: O:K OK that’s fine (0.5)
 ((nod))
 55 D: [((nodding))]

This is a subtler example, from case 2. While attempting to explain where her husband is in 53, D attempts some more complicated gestures and attempts verbalization. TR however glosses over this potential source of trouble with no attempt at repair or probing. The use of “that’s fine” in 54 seems to imply “you don’t need to try.”

Simmons-Mackie and Kagan (1999) note that abandoning an unsuccessful repair is damaging to face, especially if done without any acknowledgement of information received, or signals of “trust” with information received. The nurses in these examples attempted to “soften” the abandonment with placating actions, thus minimizing damage to face. Transaction is naturally compromised here, but the nurses attempt to manage the situation in a way that preserves interaction as much as possible.

Summary – avoidance of trouble

These strategies show it is possible to move a conversation away from trouble without undertaking repair. This kind of behaviour has been noted in other studies on aphasic conversation, such as Lindsay and Wilkinson (1999), who note how working to minimize the interactive consequences of aphasic troubles in talk includes “glossing over” potential sources of trouble at times. Simmons-Mackie and Kagan (1999, p 817) viewed this as a positive feature - “[good partners] used strategies that helped the aphasic partner save face, rather than emphasize the exchange of complete or accurate information”. In the data here, this practice was often face-saving for both participants, but it also appeared to be achieved by ignoring aphasic partners’ contributions and feigning understanding. This is counter-productive in a conversation, as transaction is severely compromised for the sake of interaction. It also does

Cunningham and Ward (2003) identified two types of unsuccessful repair in their study: discordance, where there was evident frustration during the interaction leading to irresolution of repair, and abandonment, where the trouble source was effectively ignored without agreement but no observable frustration. In this data, there were very few instances of the former type (discordance), but many of the second. The nurses did not seem to gain the aphasic partners' agreement on what to follow up or ignore. As the linguistically stronger participants, they were in a position to be autocratic regarding conversational management. Conversation thus becomes less truly collaborative.

The extracts above have illustrated how the nurses were able to deal with trouble in a face-saving manner, or gloss over potential sources of trouble. It appeared that the nurses were often oriented towards avoiding the appearance or the impression of trouble in the conversation. This end was also achieved in some cases by conducting the conversation in such a way that the potential for trouble was minimized, thus eliminating the need for repair.

Turns can be constructed so as to prefer an agreement or disagreement (Pomerantz, 1984). A question can be built in such a way as to exhibit a preference between a “yes” or “no” response, and answerers will tend to pick the choice that is preferred. This illustrates a general principle: the preference for agreement in conversation (Sacks, 1987). The nurses were able to turn this preference to their advantage by posing questions in “rhetorical” form, which projects a positive response more strongly than a straightforward question.

[illegible]

In 110 (“you don’t get nauseous or anything else, hey?”), TR is casting her question with a strong preference for agreement. The tag “hey?” at the end of the turn transforms what is essentially a statement into a question. Using interrogatives or interrogative tags (e.g. “isn’t it?”) give a format to invite and constrain subsequence (Pomerantz, 1984). This question construction was noted frequently across all six cases. Note that D has already agreed with TR in 111 (shaking her head). This type of quick, overlapping agreement is often observed in agreement-preferred/agreement structures (Pomerantz, 1984). TR’s question is phrased to almost-guarantee simple agreement, and hence preclude trouble.

- 86 → LV: But you did progress a lot now, hey?
 87 S: O::h yes. I (3)
 ((up gesture))
 88 LV: I can see when you walk with Elaine today, I saw you walking
 89 S: ((laugh))
 90 LV: I saw you wal[king].
 91 S: [ja, (I wal[king).
 92 LV: [ja::

86 (“but you did progress a lot now, hey?”) is another typical rhetorical question. S agrees in 87, and seems to attempt an expansion (gesturing upwards). LV does not directly acknowledge or clarify this, but moves on with further confirmation (88 – “I can see when you walk with Elaine today, I saw you walking). S can do little else but agree. Here, persistent close-ended contributions from LV have the effect of curtailing S’s participation.

A rhetorical question is used to resolve trouble in case 4 below.

- 192 SS: =and your family, they they come and visit you every[(.) day now
 193 A: [ye:s yes
 194 SS: and your children?
 195 A: no: (0.7) no no no?
 196 → SS: they do come, hey?
 197 A: yes=
 198 SS: =the children=
 199 A: =ja

SS’s question in 194 (“and your children?”) is initially met with a “no” (195) from A, but she almost immediately self-corrects (“no no no?”), using rising intonation to signal a request for clarification. A treats 195 as such, and poses a rhetorical question in 196 (“they do come, hey?”), which A then agrees with. Consider that SS has produced a rhetorical question rather

than an alternative, such as “do your children come?” By using the former construction, an agreement is more strongly preferred, resulting in a sequence with a greater appearance of affiliation.

Rhetorical questions are almost guaranteed to elicit agreement, and in these cases they almost always did. This allowed the conversation to continue without much scope for trouble to develop – because the aphasic partners had little chance to elaborate or disagree. The nurses were using the principle of sequential implicature to constrain the aphasic’s turns. An appearance of positive interaction was maintained, although little transaction was occurring.

3.3.2. Statements as questions

The preference for agreement was even more strongly expressed when nurses phrased contributions as statements rather than questions. This occurred most frequently in topic-opening position. Here is a typical example from case 6.

- 45 → LV: You go home today, [j]ust for the weekend.
46 S: [(o:h ye:s), I go home x x x
((pointing))

LV’s contribution in 45 (“you go home today, just for the weekend”) is a statement, both syntactically and intonationally. However, in the context of the conversation, it can be seen as a question – some request for confirmation is implicit. Schegloff (1984b) points out how actions in conversation are given a function by their sequential placement, rather than their form. This means that an utterance that falls into a particular syntactic category (e.g. question, imperative) may not be fulfilling that function in its sequential context in a conversation. Here, using a statement that functions as a question strongly prefers an agreement, which avoids the potential for trouble.

RC demonstrates another typical example in case 5.

- 243 → RC: So you haven’t got other friends in the, in the hospital here.
244 W: (no)
((shakes head))

RC's contribution is essentially a hypothesis (based on her knowledge of the situation), expressed with a degree of certainty. Note the use of "so" at the opening of the turn, a very frequently-used discourse marker for this type of structure. It implies a foregone conclusion.

205 → SF: so otherwise you're alright=
206 H: =m[m
207 → SF: [no problems=
208 H: =mm=
209 → SF: =only glad you going home=
210 H: =mm-hm
((smiles))

"So" is used again in 205. SF (case 1) is producing a series of turns almost guaranteed to elicit agreement. The speed and overlap observed in this sequence illustrate H's anticipation of the answer, as well as the fact that she is giving the preferred answers.

As can be seen from some of these examples, the nurses quite frequently appeared to be asking questions they already know the answer to. In this way, they could attempt to ensure agreement in the conversations, and with it, the appearance of mutual understanding and affiliation. The nurses were able to construct sequences with almost guaranteed avoidance of difficulty - there is little opportunity for trouble to raise its unwelcome head here. However, little real exchange of information was taking place. Again, a trade-off between interaction and transaction is occurring.

3.3.3. Extended turns

The rhetorical questions and statements discussed above tend to cast the aphasic participant in a passive role in the conversation – little else is required of them, other than to agree and acknowledge. As the linguistically stronger participants, the nurses were able to manipulate and direct the conversation in this way. This could be especially seen when nurses embarked on extended turns. In an extended turn, one participant holds the floor over a number of contributions, while the listener usually provides minimal tokens to show acknowledgement and allow the speaker to continue (Jefferson, 1984a).

TR demonstrates this very well in case 2:

195 TR: ((nod)) That's it. I'm happy to hear (.)=

196 D: mm
 ((nod))
 197 TR: =that you are happy (.) and everything is fine
 198 D: mm
 ((nod))
 199 TR: ((nod)) that you still more treatment for you
 200 D: ((nod))
 201 TR: So I hope (.) you enjoy the rest of your living here at Booth
 202 D: [((nod))
 203 D: ((laugh))
 204 TR: And I hope you look after yourself when you go [home (.)=
 ((nods))
 205 D: [((nods))
 206 TR: =The same happiness you received here by us (.)=
 207 D: [((points to self))
 208 TR: =I hope the same happiness will be at home.

TR holds the floor here over several turns, making comments and statements that do not require any contribution from D. D does contribute, but these act only to affirm TR. The effect is of extended agreement. This type of sequence demonstrates very positive affiliation, but simultaneously limits D's potential to contribute.

174 SF: ne? You must try to give up smo[king
 175 H: [mm
 176 ((nod))
 177 (3)
 178 SF: and you must (.) eat (1.6) the right food at home=
 179 H: =mm
 180 SF: No cake
 181 H: mm
 182 (0.6)
 183 SF: Or else the sugars gonna get high, ne?=
 184 H: =mm

Here (case 1), SF has been asking whether H is ever going to give up smoking. Having ascertained that H is most probably not going to, SF uses an extended turn to give advice. SF presents a series of comments/questions that H has little choice but to agree with. H's potential to contribute to the conversation is again constrained, but this ensures that the conversation moves forward quickly and without trouble.

The reverse of Jefferson's (1984a) "perverse passive" is occurring here: the aphasic partners are forced into a passive role in the conversation, since the nurses' turns project and require little else but acknowledgement. Fleming (1989, in Perkins, 1995) found that aphasics used

large numbers of these tokens: this enabled them to take part in the conversation, while minimizing the need to produce turns with greater linguistic demands. The partners can project a positive interaction, although in terms of transaction, the aphasic is contributing almost nothing to the conversation

Summary – limiting the potential for trouble

These examples further demonstrate how the nurses were able to avoid trouble in the conversations – in this case, by limiting the potential for it to occur. As the linguistically stronger partners, the nurses were able to manipulate the conversation in this way and dominate the floor. While this allowed the conversation to continue in a way that involved the aphasic and avoided trouble, little real communication was taking place. As with the other patterns in the data, the nurses appeared to be primarily concerned with minimizing visible trouble.

3.4. Summary of findings

The patterns of behaviour that have been highlighted in this section are summarized, with descriptions and explanations of their effect on transaction and interaction, in Table IV.

Table IV: Summary of results: patterns of behaviour observed in the conversation.

Behaviour	Description of behaviour	Effect on transaction and interaction
Repair of trouble in a way that minimizes interactive consequences		
Strong repair	Use of other-repair initiators that focus repair work and minimize collaborative effort (e.g. offering candidate hypotheses)	Achieves transaction, as mutual understanding is reached. Promotes interaction, as saves face in a potentially delicate situation.
Interruptive strong repair	Cutting off aphasic contributions to carry out strong repair	Achieves transaction. Quick resolution of trouble promotes interaction, but lack of respect for turn-taking damages it.
Simplification of task	Altering a question to project less linguistic demands on the aphasic (e.g. using yes/no questions, options, non-verbal modalities)	Achieves transaction most of the time. Interaction is promoted as trouble is avoided, but may be handled condescendingly.
Agreement sequences	After a sequence where trouble is repaired, prolonged confirmation sequences where aphasic repeatedly provided agreement tokens	Ensures correct transaction of information. Enhances interaction by providing a clear display that mutual understanding has been reached.
Repeated confirmation	Repeating information to gain extra confirmation	Ensures correct transaction of information. Generally enhance interaction by providing a clear display of understanding.
"Glossing over" potential sources of trouble		
Paraphrase	Providing a paraphrase of a troublesome contribution	Transaction can be achieved, but the nurses tended to over-represent the aphasic's success in conveying information. Interaction is promoted by making the aphasic look like a more competent communicator.
Continuing with next relevant turn	Producing a next relevant turn after a troublesome contribution	Transaction can be achieved, but was compromised in some instances. Interaction is promoted by making the aphasic look like a more competent communicator, but only if the transaction is successful.
Summarizing previous information	Curtailing trouble by providing a summary using previous information	May sacrifice transaction of information by avoiding troublesome turns. Promotes interaction by ensuring a topic closes on agreement.
Minimal tokens	Responding to troublesome contributions with acknowledgers (e.g. "oh", "OK", "mm")	May sacrifice transaction if the strategy is used to feign understanding. Promotes interaction by demonstrating acceptance of aphasic's contributions, but could damage it if overused (e.g. no further expansion of topic).
Topic shift	Moving the conversation away from trouble by shifting topic.	Sacrifices transaction as the aphasic's contribution is left unresolved. May promote interaction by avoiding a display of trouble, but this strategy needed to be used carefully to avoid seeming domineering.
Topic abandonment	Openly abandoning a topic. Always occurred with placating and reassurance.	Sacrifices transaction. Poses a threat to interaction, although it preserves it by avoiding further trouble and possible unsuccessful repair.
Managing the conversation to minimize potential for trouble		
Rhetorical questions	Questions in rhetorical form. Agreement strongly preferred.	Little transaction from the aphasic. Some interaction promoted, but the conversation became unbalanced in terms of floor sharing.
Statements	Opening topics with statements that functioned as questions. Agreement strongly preferred.	Little transaction from the aphasic. Some interaction promoted, but the conversation became unbalanced in terms of floor-sharing.
Extended turns	Nurse holds the conversational floor. Aphasic only required to produce acknowledgers.	Minimal transaction from the aphasic. Some interaction promoted (as aphasic still involved), but the conversation became very unbalanced in terms of floor-sharing.

4. GENERAL DISCUSSION

4.1. Discussion of results

Before further discussion of the results is undertaken, three issues must be mentioned: the reliability of the interpretation, the variability (and similarity) between the conversations, and the levels of analysis that were considered or excluded. Following this, an overview of the results is provided.

4.1.1. Reliability of the interpretation

As aspects of the interpretation of the data involved making judgments on the saliency of particular patterns in the conversations (e.g. behaviours that were noticeable, or very noticeable), a peer review of the data was undertaken to verify the reliability of this interpretation. Case-by-case discussion revealed that the raters were in agreement with the researcher and each other regarding the presence of the interactive patterns identified, as well as with the general interpretive theme. This suggests that the study provides a reliable reflection of the data.

4.1.2 Variation and similarity between the conversations

Although the data corpus in this study has been treated as a whole, in order to highlight general trends in the conversations, this does not imply that each conversation was identical in terms of strategies used. In fact, some marked differences were noted in interactional style between the cases. This can be attributed to both the different characteristics of the nurses, and the different characteristics of the aphasic participants.

Each nurse seemed to favour her own particular set of strategies to manage trouble. For example, SF was particularly prone to interruptive repair, TR and RC to using minimal tokens, and LV to topic shift. Table V reflects the behaviours that were noted in each particular conversation.

Differences in personality also contributed to the style of interaction: some nurses were simply more talkative than others, some more formal, some more humorous, some more dominating, and so on.

Table V: Comparison of behaviours observed across cases

Type of behaviour	Behaviour	Case 1 SF/H	Case 2 TR/D	Case 3 AR/G	Case 4 SS/A	Case 5 RC/W	Case 6 LV/S
Repair to minimize interactive consequences of trouble	-Strong repair	*	*	*	*	*	*
	-Interruptive repair	*		*	*	*	*
	-Simplification of task	*	*	*	*		
	-Agreement sequences		*	*	*	*	
	-Repeated confirmation	*	*	*	*	*	*
Glossing over potential sources of trouble	-Paraphrase	*	*	*	*	*	*
	-Next relevant turn			*	*	*	
	-Summarize		*	*	*	*	*
	-Minimal tokens		*	*		*	*
	-Topic shift	*	*	*	*	*	*
	-Topic abandonment		*	*	*	*	
Minimizing the potential for trouble	-Rhetorical questions	*	*	*	*	*	*
	-Statements		*	*	*	*	*
	-Extended turns	*	*	*	*	*	*

* denotes an observed behaviour

On the other hand, differences between the aphasic participants also impacted on the conversations. For example, aphasic participants who were fluent, like W, held the floor more easily, whereas non-fluent aphasics, like H, tended to lose it. Several authors (Lesser and Milroy, 1993; Lesser and Algar, 1995; Perkins, 1995) have noted how the precise nature and severity of the underlying linguistic impairment influences conversational management in aphasia, which was observed here too. It must also be noted that, linguistic resources aside, the aphasic partner's personalities impacted on the interactions - as with the nurses, some aphasics were more reserved, some more humorous, some more assertive, and so on.

While these differences are interesting and possibly the site for further investigation, the aim of this study was to focus on generalities in behaviour, not specifics. The analysis of behaviour showed that all the nurses conformed to the same over-riding patterns in the conversations (i.e. minimizing the consequences of repair, glossing over trouble, minimizing potential for trouble). These patterns were just manifested in different ways, depending on the characteristics of the nurse and the aphasic participant. This finding suggests that this study has uncovered a valid orienting principle in nurse-aphasic conversation.

4.1.3 Aspects of conversation considered and excluded

One of the limitations of this study as an ethnomethodological endeavour was the fact that the data was not completely naturally occurring. Consideration of this factor was exercised during analysis in order to avoid drawing invalid conclusions. This resulted in the analysis coming to concentrate on a fairly micro-structural level of conversation. The more macro-structural level (such as issues pertaining to topic - choice, maintenance and shift) was largely excluded, primarily because the contrivance of the situation became very apparent at this level. To take an example from case 6 (simplified transcription):

- 120 LV: Ja, and now what can I say. Ek weet nie wat om te se nie. Heere⁵.
121 S: ((shaking head))
124 LV: You feeling, you can feel when you need to go to the toilet, ja?=-

Here, the next topic is selected for convenience rather than contextual relevance. The ecological validity of this behaviour is questionable, as it was unlikely to occur outside the data collection situation. The process of negotiating meaning with the aphasic within a sequence, on the other hand, is something that is more likely to be natural. This echoes Pomerantz and Fehr's (1997) observation that if participants know a recording device is present, they will alter some aspects of conversation (like topic choice), but not others (like coherence).

There were also numerous other behaviours that were noted in analysis (such as laughter, physical contact, metalinguistic comments, testing questions) that have been excluded from discussion, merely in order to focus the purpose of this study. The practices that have been discussed were selected for their salience in the conversations, and the way they acted together to produce observable patterns in the conversations. There is nevertheless still much scope for further analysis of the data collected in this study.

4.1.4 Overview of results

In summary, the over-arching theme that became apparent during analysis of the data was the way the nurses worked towards minimizing the visibility of trouble in the conversation. This was reflected in three main findings: a preference for repair strategies that did not bring

⁵ Translation from Afrikaans: "I don't know what to say. Oh lord."

trouble too close to the conversational surface; a tendency to “gloss over” potential sources of trouble; and a style of managing the conversation in such a way that the potential for trouble is minimized. Thus, repair was carried out as quickly as possible, some trouble sources were not pursued, and the nurses held the floor in a way that limited aphasic contribution. In addition, the nurses often tended to produce many visible signs of understanding (paraphrases, acknowledgement tokens, confirmations). The observable consequence of these strategies is that the appearance of intersubjectivity and trouble-free conversation was maintained as much as possible. This promoted the goal of interaction in many instances, but tended to compromise the goal of transaction: to varying degrees, exchange of information was sacrificed in order to maintain some semblance of the “flow” of conversation. A peer review of the data indicated strong agreement with this interpretive theme.

4.2. Interpretive theme: how to “stay out of trouble”

The behaviours described above can be seen to achieve a single objective: to “stay out of trouble” (using both CA and conventional implications of the word trouble). This appeared to be the nurse’s primary concern – to mitigate the effects of aphasia on the conversation by avoiding the breakdowns that it incurs. The nurses were all adept at avoiding the problematic consequences of aphasia, but the kind of strategies this required often sacrificed transaction. By minimizing the effects of aphasia, the nurses’ agenda for the conversations seemed to be to promote affiliation – however, it is debatable whether they achieved it. The reasons for this pattern, and its positive and negative implications, are considered below.

4.2.1. Why would partners try to stay out of trouble?

As has been repeatedly demonstrated in CA studies, trouble is an interactionally delicate matter, as troubles in talk have the potential to reveal a participant as “non-competent” (Kagan, 1995). The absence of trouble and repair in a conversation, on the other hand, implies that the participants are achieving intersubjectivity (Schegloff, 1992). Thus, the nurses’ tendency to minimize interactive phenomena that imply lack of understanding can be seen as a means of saving face for the aphasic participant. The nurses can be seen to manipulate the conversation in an attempt to cast the aphasic as a more competent communicator.

This relates strongly to Goffman’s (1955) concept of “face-work.” Members of society take care to maintain face (self-image) – their own faces and those of others, which requires some

work to be done in social situations. This face-work regulates interaction and prevents embarrassment. The nurses are thus attempting to save the aphasic partner's face by minimizing the trouble in the conversations, as trouble displays the aphasic as non-competent.

It is notable that other research has shown that not all conversation partners try to stay out of trouble. Some partners explicitly bring trouble to the surface by prolonging repair sequences (Lindsay and Wilkinson, 1999), while others project discordance more subtly (Simmons-Mackie and Kagan, 1999). Why do the nurses in the present study display this particular orientation to conversation? One possible reason is that they are not very well-acquainted with their partners, and do not want to let them lose face (whereas a more established relationship can tolerate embarrassment). A second possible reason is that having all worked for many years in the rehabilitation setting, the nurses are accustomed to interacting with aphasic patients and have developed strategies to avoid embarrassment in conversations.

4.2.2 What is good about staying out of trouble?

Superficially, avoiding the appearance of trouble in conversation could be judged as a "good" behaviour. The observable results it has on the interaction are those that are generally viewed as positive in aphasic conversation.

Facilitating the conversation

Many of the nurses' behaviours can be described as facilitative. Their use of strong repair strategies stops the burden of repair falling on the aphasic partner, which is a feature of co-operative conversation partners (Milroy and Perkins, 1992). The nurses' strong involvement in the conversation and readiness to repair results in sequences being resolved successfully and the conversation being moved forward smoothly. Oeschlaeger and Damico (1998) and Ferguson (1996) discuss how using facilitative strategies such as these establish the perception of communicative competence. The nurses are seen to use many of the strategies that Kagan (1995) suggests to reveal competence: they adapt their talk (e.g. using yes/no questions), they support the talk with resources (e.g. non-verbal strategies), and they often verify responses to make sure interpretation meets with the aphasic's approval. They do not prolong repair, openly correct productions, or withhold repair, which have been identified as having a potential negative effect on the conversation (Lindsay and Wilkinson, 1999; Ferguson, 1994; Booth and Perkins, 1999; Wilkinson et al, 1998). Thus, superficially, they

are managing the conversations in a collaborative, face-saving manner that is often encouraged in partner studies.

Promoting interaction

Proponents of the social model to aphasia emphasize that interaction is as important as transaction in conversation (Simmons-Mackie, 2000). In Simmons-Mackie and Kagan's study (1999, p 818), "the good partners actually sacrificed transactional goals to some degree to help aphasic partners save face and foster positive engagement." Simmons-Mackie and Damico (1997) point out how a priority for aphasics is the interaction, the "flow" of discourse. In many ways, the nurses could be seen as focused on achieving interaction or flow: there is little discordance or stoppage in these conversations. There are also "indices of intimacy" (Jefferson, 1974) in the conversations, such as laughter, agreement and congruent overlap, which suggest successful interaction.

Thus, one must recognize that much of what the nurses did can be judged very positively, even though they had not received any formal training on communicating with aphasics. It should be remembered that these nurses had worked in an environment with aphasic patients for an average of over ten years, which would imply that their style of interacting was developed through experience. However, even a casual reading of the data gives the impression that something was very much lacking from the conversations. These problems can also be explored and explained through CA methodology, and are discussed below.

4.2.3. What is wrong with staying out of trouble?

As noted above, the participants overtly seemed to be placing a priority on achieving interaction. This however frequently occurred at the expense of transaction - and often, interaction was compromised as well.

Feigning intersubjectivity

Although all the nurses were capable of running superficially successful conversations, often little true exchange of information was taking place. In many instances it appeared that the nurses were willing to sacrifice understanding for the sake of maintaining an impression of it. There are conventions for displaying intersubjectivity (Schegloff, 1992), which the nurses manipulated in order to avoid trouble. This occurred when they produced confidently-phrased paraphrases based on problematic turns, or used opaque acknowledgement tokens to avoid

displaying understanding. The suspicion of feigned understanding was particularly strong in some instances. This undermines the communicative process, and is essentially condescending to the individual with aphasia – it conveys no respect for, or trust in, his or her capability for contributing to a conversation. This is comparable to the interpretation reached by Simmons-Mackie and Kagan, (1999), where “bad” partners were seen to project doubt on the competence of the aphasic partners. However, in the present study this occurred in a more subtle manner, with less overt discordance.

Constraining the aphasic participant

In this data, the impression of intersubjectivity and conversational flow was generally achieved by the nurses maintaining a stranglehold on the conversation. The nurses, being the linguistically stronger partners, were able to keep tight control over the floor, thus regulating the number, length and type of turns the aphasic partners could produce. This was reflected especially in interruptive repair, where the aphasic partners were not given a chance to repair their own contributions, or even finish their own turns. The nurses could limit what the aphasics were allowed to produce in the conversation using the principle of sequential implicature (Schegloff and Sacks, 1973), constraining them to yes/no answers. Giving the aphasics only linguistically easy tasks to complete avoided the potential for trouble in the conversations, but also limited the scope of the communication. The aphasic partners were often placed in a very passive role, merely agreeing with rhetorical questions and allowing extended turns. As well as constraining the aphasics in the conversations, the nurses were able to avoid having to show understanding of troublesome turns, by using general paraphrases, vague summaries, or topic shift. With the nurses not following their cues, the aphasic partners were being effectively ignored.

In aphasic conversation, it is usually seen that the non-aphasic partner will take on more of the “work” of conversation (Ferguson, 1994; Milroy and Perkins, 1992). Here, however, the nurses’ exercise of control over the conversation produced an asymmetrical balance of power that made the conversation a less collaborative event. The nurses assumed full responsibility for maintaining the conversational flow, which meant the aphasic partner could not contribute to the conversation on their own terms. This asymmetry in the conversations, while it prevents overt signs of incompetence, does not reveal competence either (a problem typically seen in aphasic conversation – Kagan, 1995). It essentially undermines the aphasic’s capabilities as a conversation partner, by depriving them of any power in the interaction.

Lack of trouble is abnormal

The avoidance of trouble thus did not ultimately produce a more natural conversation. Although trouble is indicative of difficulty understanding, it is a normal feature of conversation. Ferguson (1994) points out how previously in the field of aphasia, there has been a tendency to view repair as disruptive and associated with, or indicative of, the presence of pathology. However, the findings of her study (and others) support the view of “repair as a normally occurring resource in language which is potentially available for greater use when communication becomes more troublesome” (Ferguson, 1994, p153). The nurse’s aversion to trouble thus made the conversations less normal, not more normal.

In summary, while “staying out of trouble” may avoid a threat to perceived competence, it does not reveal the aphasic as a competent communicator. The behaviour described here is a subversion of the positive pattern noted by Simmons-Mackie and Kagan (1999, p 818), where “good partners actually sacrificed transactional goals to some degree to help aphasic partners save face and foster positive engagement.” Here, behaviours that were intended to save face and foster positive engagement ended up limiting the aphasic partner’s capacity to contribute to the conversation, and essentially treating them in a condescending manner.

4.2.4 Paradox: balancing challenge and condescension

The results of this study are almost paradoxical. Although many of the nurse’s behaviours were very facilitative and face-preserving, the conversations tended to be superficial, non-communicative, and subtly condescending. The paradox is that the nurses are acting in a way that superficially conforms to the “good” strategies identified in previous literature, but they are not managing to have natural, adult conversations. Their strategies to preserve the “flow” of the conversation succeed, as the conversations keep moving forward with minimal stopping and discord, but only on a facile level of communication.

This relates to the central issue in conversation: the way that ongoing conversational activity is central to participants’ perceptions of mutual competence (Kagan, 1995). Lack of belief in the individual with aphasia’s inherent competence has been suggested as an underlying cause of poor interactional behaviour (Simmons-Mackie and Kagan, 1999). The nurse’s agenda for the conversation seemed to be to promote affiliation and agreement, but this interactional goal was achieved in a way that showed no real belief in the aphasic as a conversation partner. While the nurses often used actions (such as those involving feigning understanding) that

could make the aphasic partner appear more competent in the conversation, these do not really reveal true competence. Sacrificing transaction to maintain the interactive flow cannot act to acknowledge competence, as it is insincere.

Explicitly, the nurses were generally quite respectful and deferential to the patients, and showed indices of affiliation (e.g. laughing together, physical contact). Some of the nurses acknowledged competence explicitly in the conversations. A typical example occurs in case two (simplified transcription):

150 TR: I really do understand what you are talking to me,
because I can understand what you are saying to me.
So, I don't find any difficulty talking to you,
because you can actually tell me

– while her partner, D, is the most expressively impaired participant in the study. Despite these explicit assurances, the nurses were not implicitly acknowledging competence in the conversations. If the aphasic partner is denied the chance to contribute meaningfully to the conversation, little belief in their ability as a communicator is implied.

Thus, while the nurses were “saving face” for both themselves and the aphasic, the aphasic is not really being treated as someone capable of contributing meaningfully to a conversation. The nurse’s behaviour is wholly understandable – as they know all too well, individuals with aphasia do tend to have troublesome conversations, and trouble can pose a serious threat to face. The paradox thus makes sense: in their efforts to minimize the embarrassing difficulties of aphasic conversation, the nurses run the risk of sacrificing what is really important in human communication. This highlights how conversation partners need to walk a fine line between condescension and challenge when interacting with individuals with aphasia.

4.3 Theoretical implications

Expanding and explaining the idea of “glossing over” trouble

Several studies (Lindsay and Wilkinson, 1999; Lesser and Algar, 1995; Perkins, 1995) have noted how conversational partners can “gloss over” potential sources of trouble in conversation, but this phenomenon has not previously been examined in much depth. This study describes in more detail some of the practices that participants can use to accomplish this glossing over. In addition, it reconsiders the implications of such behaviour. Previously, minimizing the interactive consequences of trouble had been viewed as a positive feature of

conversation (Booth and Perkins, 1999; Wilkinson et al, 1998). In this study, this behaviour can be seen to have a less positive effect in certain contexts.

This finding reinforces the fact that conversational behaviour, while orderly, is complex, and much sensitivity is required in dealing with interactional data. Behaviours that are facilitative in one context may become condescending in another. This serves as a warning against the use of pre-conceived concepts to analyze aphasic conversation. While this is a more economical approach to data analysis, it can compromise the meaning of the behaviours.

Conversation in the context of health care

This study places nurses as the conversation partners under scrutiny, as opposed to the more conventional partners for CA studies (speech language therapists, family, friends or volunteers). The way that this data contrasts to previous studies shows how conversational practices may vary between different contexts and participants. Factors such as familiarity and social identity are likely to be made relevant in these conversations (as suggested by several authors - Lesser and Milroy, 1993; Lindsay and Wilkinson, 1999). In the context of nurse-patient interaction, the relevant factors might be suggested to be the following:

- The nurses are familiar with aphasia, through their work experience, and would have already developed strategies for coping with the communication barriers it entails.
- The nurses are less familiar with any specific individual aphasic patient they are interacting with, which implies they would be less likely to risk a loss of face.
- The nurses are professionally caring for the individual with aphasia, a relationship which implies a degree of mutual deference.
- In the busy hospital environment, nurses might not have time to spend long interacting with aphasic patients – staying out of trouble would therefore be an economical strategy for them.

Additionally, although this study has focused on aphasia, it does not necessarily imply that the nurses' behaviours were only the result of their partners being aphasic. Other studies on nurse-patient interaction (Ashworth, 1980; Field, 1982; Lubinski, 1995) have highlighted how communication in care settings can be undervalued and impoverished. It is entirely conceivable that nursing staff may "stay out of trouble" with non-aphasic patients as well, in similar or different ways. This study therefore potentially contributes to the broader field of nurse-patient interaction.

Finally, while this study involved nurses, the practices identified could hypothetically manifest in any conversation or conversation partner. This study has therefore added to the “repertoire” of patterns available to analysts looking at aphasic conversation.

Evaluating conversation analysis

A study of this nature can be used to evaluate CA as a tool for describing aphasic conversation. The value of CA in aphasiology has been stated before (Lesser and Milroy, 1993; Perkins, 1995; Damico et al, 1999), and the present study provides further support for this. The primary value of CA in this study was to uncover and account for a conversational behaviour that was suspected, but not immediately apparent in the data. By its focus on context and detail, and its inductive approach to analysis, CA can be a powerful means of demonstrating new insights on aphasic conversation, while at the same time providing rigorous evidence for concepts. This study initially took a fairly “pure” CA approach, although some deviations in methodology developed later (i.e. consideration of how participants may be feigning comprehension goes beyond what is observable in the conversation, as does the more general interpretation of participants’ intentions). This type of application and extension of CA is necessary for it to be theoretically and clinically useful. In summary, this study has again demonstrated the value of CA as a means for explaining real-life aphasic conversation, and to answer the call for more ethnographically-based descriptions of aphasic communication (Worrall, 2000)

4.4. Clinical implications

The initial motivation for this study was to provide information to guide training for nurses in communicating with aphasics. Its results have not yielded a prescriptive list of “do’s and don’ts”, but rather a heightened sensitivity to a particular feature of nurse-aphasic conversations.

Value of conversation analysis for training

This study can firstly be used to consider the question of whether CA can be used to derive useful information for training. Its value in providing individualized advice to partners has already been demonstrated (such as Wilkinson et al, 1998; Booth and Perkins, 1992). In this context, however, guidance for more generic training is required, as one would want a nurse to be able to interact with a range of aphasic patients. CA makes conversational phenomena

more obvious, so that they can be discussed and altered (which is what using CA in partner training is essentially about). What this study has done is to highlight a particular way that aphasia impacts on communication, namely how an attempt to maintain interaction can sometimes negatively influence a conversation. This is a clinically useful finding, as any training aiming to improve the facet of interaction would need to take this into account.

This study highlights how much sensitivity is required in dealing with conversational data. The implications for partner training are that it is not sufficient to target surface behaviours – the nurses were already using superficially facilitative strategies in many cases. Instead, training for partners should aim to increase their awareness and sensitivity to what is accomplished by conversation. This study reinforces Simmons-Mackie and Kagan's (1999) perception that change should be more than merely promoting the use of "positive" features in conversation, but requires a change of perspective in the conversation partner. CA highlights the influence of aphasia on conversations in a way that provides insights into the nature of interaction, not didactic lists of desirable behaviour.

Recommendations for training

The above notwithstanding, it is appropriate to make some suggestions as to how these findings can be clinically beneficial. Based on the problems seen in this data, nurses should be educated about how trouble is normal in conversation, and how it can be dealt with openly, and still in a face-saving manner. It should be demonstrated how it is more respectful to acknowledge difficulty than to gloss over it. Most importantly, training and education should instil the idea that individuals with aphasia primarily need to be treated as competent adults who are capable, with the right facilitation, of engaging in conversation. The methodology described by Bryan and Maxim (1998) of showing videos to care staff and using them for discussion would seem to lend itself to this endeavour – Wilkinson et al (1998), using a similar method with couples, point out how a problem-solving rather than a prescriptive approach to partner training can be more beneficial. As explained above, the aim is not to teach specific strategies, but produce more aware and sensitive conversation partners (and the strategies will follow). Such intervention would ideally promote more genuine, satisfying interactions between nurses and aphasic patients, which would be beneficial for both partners.

While the findings of this study are relevant in any context, they may be seen to have particular relevance in South Africa, as a country with scarce resources where pragmatically-

based approaches may be more economical and effective (Penn, 1993). Intervention aimed at the level of participation has the greatest potential to be time and cost-effective (Pye et al, 2000).

4.5 Limitations of the study

The limitations of this study centre around speculations on validity. The main drawback of the study is that the analysis is not based on truly natural (i.e. spontaneously occurring) data: there is an element of contrivance in the conversations, and thus they do not represent the ideal source for ethnomethodological analysis. One striking feature of the contrived situation is that the nurse did most of the topic initiating. Besides a few instances, there is limited evidence in this data on how nurses handle the conversation when the aphasic is initiating (i.e. where the nurse does not have knowledge of the topic). The nurse may not always have the option to stay out of trouble in this situation. Had the data been collected under more natural circumstances, the participant's behaviours may have been different. As it is, the behaviours highlighted here may be more products of the setting rather than general features of nurse-aphasic interaction.

For a CA study, the sample of six dyads was relatively large, but in terms of generalizability, this group is small. In particular, this study targeted more severely impaired individuals with aphasia – it is possible that the dynamics with less impaired individuals would be different, as they may assert greater control in the interaction. It is also possible that other nurses may have behaved differently, such as by prolonging repair and exposing trouble in a manner that has been demonstrated before in aphasic conversation (Lindsay and Wilkinson, 1999). However, the fact that all the nurses in this study oriented to the same principle (staying out of trouble) suggests it may be a salient feature of many conversations. Finally, it could be relevant that all the participants in the study were (coincidentally) female – gender may or may not be a relevant factor in shaping conversational behaviour in this context.

Given the goals of the study, these threats to validity are not critical – the aim was to explore the possibilities of what the nurses could do, not to provide a comprehensive, representative description of all nurse-aphasic conversation. The principle of staying out of trouble appeared in all the conversations described in the study, and is entirely likely to operate elsewhere. In the same way that CA researchers appeal to the native knowledge of their readers as conversationalists to support their interpretations, this study must appeal to the knowledge of

its readers as individuals with experience in conversing with aphasic people. If the interpretations here “resonate” with the reader, they can be made useful – if they do not resonate, examples of the data is available for alternate accountings of the behaviour displayed.

4.6. Recommendations for further research

This research provides further motivation for more CA research in aphasiology, as a methodology that can generate findings of both theoretical and clinical relevance. Damico et al (1995) have urged the adoption of ethnographic research designs that require, rather than limit, the study of complex phenomena in their naturally occurring states and forms. CA fulfils this directive, as it has the analytic power to describe the details of real-life interaction in a way that can translate into guidance for intervention.

The use of CA for aphasic conversation in health care settings is still limited. The field will only benefit from studies drawing on a greater pool of data using participants in this setting, in a greater number of contexts. The communication skills of staff involved in caring for aphasics in the health system are important - focusing intervention on the conversation skills of nurses will help efforts to improve communication access for aphasics in the health care system (Kagan and LeBlanc, 2002), and lessen the psycho-social effects of aphasia in the health care setting (Simmons-Mackie, 2000). Further exploration of conversation in the health care setting (using, if possible, more naturalistic data collection methods than this study) is necessary.

This study has highlighted the practice of “staying out of trouble.” Now that it has been identified, more focused exploration of this concept can be undertaken. Two potential areas for investigation that are suggested by this study are consideration of how the linguistic characteristics of the aphasic partner influence trouble management (e.g. severity, fluent or non-fluent), and more thorough description of how the sequential context allows for different trouble-avoiding strategies to be employed at different times.

Finally, this type of description should eventually inform the design of partner-based intervention. This study has implied that training should educate and sensitize partners, rather than using a prescriptive, behaviour-centred approach to training, but only practical application and evaluation will support or refute this claim.

5. CONCLUSION

By applying conversation analysis to six conversations between nurses and adults with aphasia, this study has highlighted a particular interactional practice. This practice involved the ways in which a non-aphasic partner can create the impression of mutual understanding, agreement and interactional flow in conversation, while sacrificing exchange of information and compromising respect for the competence of the aphasic partner. This was achieved by the nurses in this study through the use of observable strategies to avoid visible trouble in the conversations. Despite individual differences in style, all the participating nurses were found to be oriented towards this goal. This was interpreted to be an attempt to preserve the superficial interactive features of the conversation by “staying out of trouble”. Although the nurse’s behaviour was overtly aimed at making the aphasic partner seem more competent, and thus save face for them, it did little to reveal their competence. The aphasic partner’s capability to contribute, and the nurses’ respect for their contributions, was often limited by this behaviour. This pattern has the potential to occur in any setting, especially where the participants do not wish to risk loss of face. Thus, it is an important factor to consider in partner training, where the desired outcome is genuine preservation of interaction and not just a shallow semblance of it. Theoretically, this study explores a new aspect of conversational behaviour, within a health-care setting. Clinically, it advocates for programs for generic partner training to sensitize their targets towards this type of behaviour.

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LIST OF APPENDICES

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Appendix A

Description of participants with aphasia

Case 1 – H (paired with SF)

H was a 54 year old woman who had sustained a left-hemisphere CVA, resulting in dense right hemiplegia and aphasia. She was married with one daughter. At the time of data-collection, H was six weeks post-CVA and presented with non-fluent aphasia. Her difficulties with speech production suggested a degree of apraxia.

- Mild-moderate receptive impairment

Receptively, H demonstrated a mild-moderate deficit in auditory comprehension on structured testing, being able to follow simple instructions and comprehend short, simple sentences, but struggling with longer (two-part) instructions and comprehension of decontextualized sentences. She was generally able to follow conversation without difficulty. She was able to recognize written words with good comprehension.

- Severe expressive impairment

H was severely expressively impaired. Her output was limited, and usually consisted of meaningless, repetitive utterances. She was able to produce “yes” and “no,” stereotypical social phrases and at times would produce meaningful, intelligible words in conversation (especially in closure-like situations). In other instances, her output reflected phonological paraphasia. H made minimal use of meaningful gesture. She was able to write familiar information such as her name and telephone number, but struggled with other writing tasks.

Case 2 – D (paired with TR)

D was a 62 year old woman who had sustained a left-hemisphere CVA, resulting in dense right hemiplegia and aphasia. She was widowed. At the time of data collection, D was seven weeks post-CVA. D presented with severe expressive aphasia and apraxia of speech.

- Very mild receptive impairment

D’s receptive abilities were relatively well preserved - she followed conversation well and was able to understand longer, more complex sentences. She did however have occasional difficulty with decontextualized comprehension tasks. Her reading comprehension for single words was good, and she was able to recognize the items in a communication book fairly consistently.

- Extremely severe expressive impairment

D was non-verbal. While able to spontaneously produce voice, D was not able to produce words and only occasionally was able to attempt production of any speech sound. Attempts to produce speech through modelling revealed apraxia. She could form legible letters but was not able to spell meaningful words. She frequently made use of meaningful gestures to communicate.

Case 3 – G (paired with AR)

G was a 60 year old woman who had sustained a left-hemisphere CVA, resulting in slight right-sided weakness and aphasia. She was widowed with four children. At the time of data collection, G was four weeks post-CVA. G presented with moderate expressive aphasia, and moderate dysarthria characterized by imprecise articulation and soft voice, which had a moderate effect on intelligibility.

- Mild receptive impairment

G's receptive abilities were mildly impaired, showing good comprehension of simple sentences but not more complex items. She was generally able to follow conversation without difficulty. Her comprehension of written language was preserved on a basic level.

- Moderate expressive impairment

G's expressive language abilities were moderately impaired. She was able to produce short meaningful phrases with normal fluency at times, but typically demonstrated hesitation or produced phonological paraphasias. Her spontaneous output resembled jargon at times. The combination of dysarthria and aphasia resulted in a moderate-severe difficulties with verbal communication. G's written output was limited and often illegible. She used meaningful gesture to a certain degree to communicate.

Case 4 – A (paired with SS)

A was a 38 year old woman who sustained a left-hemisphere CVA, resulting in right hemiplegia and aphasia. She was married with two children. At the time of data collection, A was four weeks post-CVA. A presented with moderately severe non-fluent aphasia.

- Mild receptive impairment

A's receptive abilities were mildly impaired, showing difficulty only with comprehension of complex decontextualized information. She followed conversation without difficulty. She did however have difficulty with comprehension of written information on single-word level.

- Moderate-severe expressive impairment

A's verbal output was limited in amount and non-fluent, consisting of short phrases or single words, with much hesitation. She occasionally produced phonological or semantic paraphasias. She was able to write over-learned words, but nothing propositional. She used meaningful gesture at times to communicate.

Case 5 – W (paired with RC)

W was an 83 year old woman who had suffered a left-sided basal ganglia CVA, resulting in aphasia. She was widowed with two adult children, and staying in an old age home. At time of data collection, she was eight months post-CVA. W presented with severe fluent aphasia.

- Very mild receptive impairment

W's receptive abilities were well preserved, although occasional difficulties comprehending extended pieces of information were observed. Reading comprehension was well-preserved.

- Severe expressive impairment

W's verbal output was copious, but consisted mostly of fluent jargon, containing occasional meaningful words or phrases, and some episodes of hesitation. A high number of phonological paraphasias were evident in her output. She was able to write legible words, although her spontaneous written output typically showed a high occurrence of spelling errors. She made use of meaningful gesture to some extent in conversation.

Case 6 – S (paired with LV)

S was a 59 year old woman who had suffered a left-sided CVA, resulting in right hemiplegia and aphasia. At the time of data collection, she was eight weeks post-CVA, and was an inpatient at a rehabilitation hospital. She was married with three adult children. S presented with severe expressive aphasia.

- Mild receptive impairment

S's receptive abilities were mildly impaired, showing difficulty only with comprehension of complex material. She was able to follow conversation without difficulty. Her reading comprehension was preserved at a basic level.

- Severe expressive impairment

S's verbal output was limited, although fairly fluent, and showed a high occurrence of phonological paraphasias. Some meaningful words or phrases were produced at times. She was able to write a little propositional information. She made use of meaningful gesture to some extent in conversation.

Appendix B

Consent form for nurses (English version)

**Division of Communication Sciences and Disorders
University of Cape Town
June 2003**

I am conducting research on how nurses interact with people with aphasia in hospitals, as part of my Masters degree. I am looking for ENAs who would be willing to help me with this.

Participation would involve being videotaped talking with a patient with aphasia for about ten minutes.

I am intending to use the information I get from this study to create a training programme for nurses on communicating with aphasic patients. Participating in this study will give you a chance to show me what in particular you find challenging when talking with aphasic patients.

Participation is voluntary. You may also withdraw from the study at any time if you choose. Anything you say or do during the study is completely confidential. In particular, information about your involvement will not be shared with others in the hospital.

The research will take place at Booth, at a time that is convenient to you.

PLEASE ask me if there is anything else you wish to know about the study.

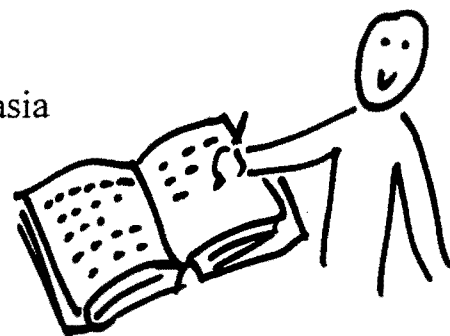
Your help would be greatly appreciated.

Kate Hoffman
Speech Therapist

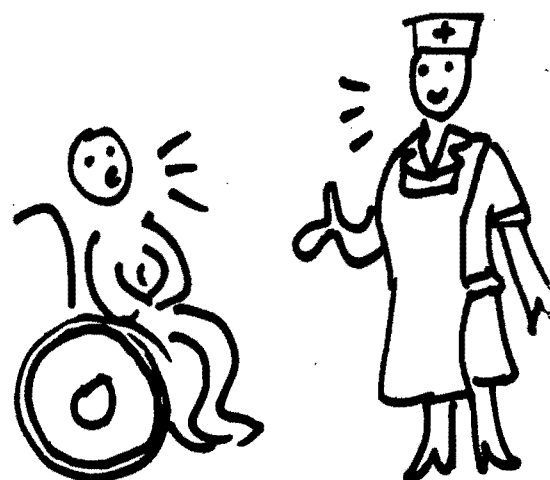
I, agree to participate in the study, "An investigation of conversation between people with aphasia and nurses". I have read and understand the information presented above.

.....
Signed

I am conducting **research** at the Booth for my Masters degree.

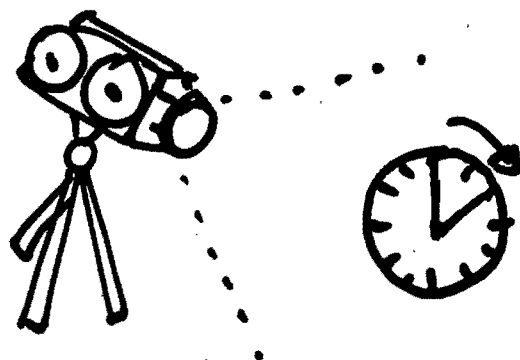


It is on how **nurses** and people with **aphasia** speak to one another.



I need patients like **YOU** to help me with this.

Being part of this study means that you will be **videotaped talking** with a nurse at the Booth for about **10 minutes**.



It is your **choice** if you want to participate.

YES / NO

Your **name** will not be used in the research report.

~~NAME~~

I, **agree** to participate in the above study. I **understand** the information above.

.....
Signed

Appendix C

Instructions to nurses before data collection

“I want to see how you manage to have a conversation with a patient with aphasia, just as you do every day that you interact with them. Spend the next few minutes talking with the patient – it can be about anything that the two of you come up with – in whatever way you normally would. If you get stuck, try finding out about the patient, their progress, their family and so on. I would like about ten minutes of talk, but you can finish whenever you feel the conversation is at an end.”

University of Cape Town

Appendix D

Rating scale used to guide discussion during peer review of data (page 1)

CASE 1

Did the nurse attempt to minimize the interactive consequences of trouble?

Never Occasionally Noticeably Very noticeably

Did the nurse "gloss over" potential sources of trouble?

Never Occasionally Noticeably Very noticeably

Did the nurse manage the conversation in such a way that the potential for trouble was minimized?

Never Occasionally Noticeably Very noticeably

How well was transaction (exchange of information) achieved in this conversation?

Poorly Adequately Well Excellently

How well was interaction (social satisfaction) achieved in this conversation?

Poorly Adequately Well Excellently

CASE 2

Did the nurse attempt to minimize the interactive consequences of trouble?

Never Occasionally Noticeably Very noticeably

Did the nurse "gloss over" potential sources of trouble?

Never Occasionally Noticeably Very noticeably

Did the nurse manage the conversation in such a way that the potential for trouble was minimized?

Never Occasionally Noticeably Very noticeably

How well was transaction (exchange of information) achieved in this conversation?

Poorly Adequately Well Excellently

How well was interaction (social satisfaction) achieved in this conversation?

Poorly Adequately Well Excellently

CASE 3

Did the nurse attempt to minimize the interactive consequences of trouble?

Never Occasionally Noticeably Very noticeably

Did the nurse "gloss over" potential sources of trouble?

Never Occasionally Noticeably Very noticeably

Did the nurse manage the conversation in such a way that the potential for trouble was minimized?

Never Occasionally Noticeably Very noticeably

How well was transaction (exchange of information) achieved in this conversation?

Poorly Adequately Well Excellently

How well was interaction (social satisfaction) achieved in this conversation?

Poorly Adequately Well Excellently